Executive Summary

Introduction – Origins of this inquiry

The Canadian health care system is premised in part on the ideal of equitable access to necessary physician and hospital services without regard to one's ability to pay for those services. Equitable access involves ensuring that patients who have the same medical conditions have the same opportunity to access the same services.

Still, there exists a pervasive belief that Canada has a two-tiered health care system, where advantage is secured, not necessarily through wealth, but through connections or status. In short, some believe that others get faster access to health care for reasons other than medical need. This perception is likely widespread, but evidence showing the existence of a two-tiered system is largely anecdotal. Nonetheless, this perception corrodes faith in the claim that Canadian health care is premised on equitable access.

The Alberta government established the inquiry under the *Health Quality Council of Alberta Act* in February 2012. The inquiry's terms of reference ordered it to consider the following:

1) Whether improper preferential access to publicly funded health services is occurring; and

2) If there is evidence of improper preferential access to publicly funded health services occurring, make recommendations to prevent improper access in the future.

Several events precipitated the call for this inquiry. In June 2011 Alberta media reported claims by the former Chief Executive Officer of Alberta Health Services (AHS), Dr. Stephen Duckett, that some of his predecessors had designated "go-to guys" who would manipulate wait lists for medical procedures. The media also referred to a 2009 document distributed to senior AHS executives claiming that it was "not uncommon for executive members or other leaders of health care organizations to receive requests to provide preferential or expedited care for 'prominent' individuals or the family and acquaintances of 'prominent' people."

The media also cited claims by Dr. Raj Sherman, MLA for Edmonton-Meadowlark and an emergency room physician, that it was common for rich and well-connected Albertans to jump wait lists for medical care. He was quoted as saying that he personally received requests from hospital executives for certain patients to get preferential treatment.

The allegations of these individuals and the claim that it was not uncommon for senior executives to receive requests for expedited care proved to be unfounded. However, the inquiry's terms of reference called on it to explore any preferential access that may be occurring within the health care system. The inquiry did in fact learn of incidents of improper preferential access and also identified several systemic issues that could foster an environment conducive to such improper access.

This inquiry was able to examine only one small corner of Alberta's complex health care system. Even for this limited review, Commission counsel interviewed more than 150 individuals. The inquiry received hundreds of emails, letters and telephone calls from the public. In total, 68 witnesses testified and the inquiry received 172 exhibits. Ten parties presented written submissions at the end of the hearings. Still, the inquiry's findings must not be taken as findings about the system as a whole.

While this inquiry uncovered instances of improper preferential access, it did not find specific evidence that anyone had been medically harmed as a result. It would be almost impossible in any event to show that giving one person improper preferential access directly harmed another – that is, short of actually seeing a patient bumped to make way for someone with the right connections.

The more significant question is whether improper preferential access causes harm to the principles underlying publicly funded health care in Alberta.

Preferential access – a definition

This inquiry has focused on actions that lead to preferential access that is improper within the context of the Canadian health care system. Yet a recurring theme throughout this inquiry has been the lack of an accepted definition of improper preferential access. Hence, there is a need to explain preferential access and the meaning of improper.

Normal access involves physicians using their professional judgment to prioritize patients based on medical necessity. This is not preferential access.

Preferential access is a type of access that, for the patient, is advantageous to that warranted by medical necessity. Whether such preferential access is proper or improper requires an examination of the specific context in which it occurs. Improper preferential access is any policy, decision or action that cannot be medically or ethically justified, resulting in someone obtaining priority access over others similarly situated. For an act of preferential access to be improper, there is no need to demonstrate actual harm. First, harm would be impossible to prove. Second, if it is improper, harm can be assumed – harm to the health care system, to its fairness, predictability and efficiency, to the public's confidence in its integrity, and harm through reinforcing the improper behaviour by its example to others.

Socially justifiable preferences: There may be tolerance within society for certain types of preferential access. However, the public needs to be involved in determining what is tolerable. This will help the provision of health care become better aligned with societal values.

The public may, for example, accept preferential access for leaders of the government. Similarly, there may be broad acceptance of preferential access of patients enrolled in research protocols. Public tolerance for providing preferential access to athletes or other celebrities may not be as great.

An individual's or profession's social utility may also be a factor in determining whether preferential access is publicly acceptable. A good argument can be made that in urgent circumstances, such as a pandemic, front-line health care workers should be inoculated first, along with their families, on the theory that sick family members would compel the health care workers to leave their duties to care for the family members. Similarly, in civil emergencies, police and firefighters should be given priority. Such preferential access would not be regarded as improper.

Determining whether preferential access is proper for those providing some other types of essential services is more challenging. There must be a clear definition of what constitutes an essential service, and in what circumstances. This can only be achieved when health care

professionals and administrators, government officials and the public collaborate in setting this definition.

Queue-jumping and multiple entry points

There are multiple entry points into the health care system, each with its own opportunities for preferential access. Circumstances that constitute improper preferential access in one situation may not be improper in another. The following examples demonstrate that there are many ways to access the health care system and, more significantly, that preferences are built into the system.

Workers' compensation: The *Canada Health Act* and the *Alberta Health Care Insurance Act* exclude from the definition of insured services those services that a person is entitled to under federal or provincial workers' compensation legislation.

There is no doubt that this practice amounts to preferential access. The exclusion of people entitled to receive workers' compensation benefits is only one of a long list of exclusions contained in the regulations enacted by the Alberta government and all other provinces and territories. Residents of Alberta who fall within one of the excluded categories can receive preferential access to services through payment for those services because of their occupation or, as with workers' compensation claimants, the circumstances in which their injury or illness arose. Whether this distinction is proper is a matter of public choice, expressed through elected representatives.

Private diagnostic imaging: A person who pays for diagnostic imaging at a private facility, instead of waiting for the same service through publicly funded channels, can receive a prompter diagnosis. If the diagnosis indicates a need for treatment, that person can immediately step into line for treatment. The person waiting for a diagnosis through the publicly funded system cannot step into that line for treatment, since he or she has not received a diagnosis. By circumventing the long wait for diagnosis, a patient who steps outside the public system for diagnosis obtains preferential access to treatment when he or she rejoins the public system.

The proliferation of private diagnostic services poses a true ethical dilemma in the context of access to health care. It undermines the principles of fairness and equity in access to health care and provides

an advantage to those who can pay for this service. On the other hand, the practice is not illegal. It is accepted by governments and by physicians' regulating bodies. Physicians may even have an ethical and legal obligation to advise a patient of the private option where they consider it to be in the medical interests of the patient and there is delay in obtaining the service in the public system.

There is no correct answer, practically or ethically, in the debate over the role that private diagnostic services play in permitting preferential access. It is a question for public discussion to define what is acceptable.

Medical tourism: Medical tourism means going out of the country for services or tests that patients could obtain in Canada but choose to pay for and get faster elsewhere. If patients pay for treatment abroad and that treatment leads to complications, they can then return to Canada where they remain entitled to publicly funded health care services to deal with those complications. They cannot ethically or legally be denied treatment or be prioritized on a different basis than others who have completed their entire medical journey in the public health care system here.

Medical tourism does not in itself constitute preferential access. It is only if the publicly funded health care system in Alberta has to respond to the consequences of medical tourism that it could become preferential access. But, because at that point there is medical necessity for the service, it cannot be labelled as improper.

Enhancing legislation on queue-jumping

Section 3 of the *Health Care Protection Act* prohibits financial incentives "for the purpose of giving any person priority for the receipt of an insured surgical service." The statutory prohibition only applies to giving priority to insured surgical services. There is no legislation or policy governing queue-jumping when no material benefit is offered. Furthermore, the prohibition does not extend to all insured health services.

Recommendation 1:

Strengthen the queue-jumping provisions of the *Health Care Protection Act*

The Government of Alberta should amend section 3 of the *Health Care Protection Act* to:

- broaden the scope of the prohibited forms of inducement;
- have it apply to all types of insured health services; and
- include a mandatory reporting requirement with provisions for the protection of people who make a report in good faith.

Physician advocacy and ethics

Advocating within the health care system for individual patients is a basic function of a physician. Besides this primary responsibility to the patient, physicians also have a responsibility to "consider the well-being of society in matters affecting health" and specific duties to "promote equitable access to health care resources," provide services without discrimination on a number of grounds, including socioeconomic status, and "use health care resources prudently."

Ethical advocacy, that being advocacy to ensure that patients receive the care that is due to them based on their medical needs, cannot be regarded as facilitating improper preferential access. It is the proper role of the physician. However, not all physicians are equally adept at this complex exercise, with its competing ethical responsibilities.

Education about ethical advocacy and development of clear guidelines will go far towards eliminating the circumstances that may lead to improper preferential access. In addition, the government's recently enacted whistleblower legislation would help if it were extended to protect independent contractors such as physicians or other health care providers. This would help protect them when they speak out about resource or policy issues or challenge improper procedures.

Recommendation 2:

Expand whistleblower protection

The Government of Alberta should amend the *Public Interest Disclosure (Whistleblower Protection) Act* to include health care professionals, such as physicians, who are not employees but who are contracted by Alberta Health Services and/or the government to provide health care services.

Professional courtesy

The inquiry heard evidence about professional courtesy, a practice where physicians in particular give priority to requests for care by other physicians, health care workers and their families. Professional courtesy produces a form of preferential access.

In Canada, professional courtesy has come to mean seeing a colleague or their family member more quickly than would occur if they were a typical patient. This is done by seeing them before or after the treating physician's regular working hours. There is, however, a lack of consensus about how far professional courtesy extends, and to whom.

The inquiry also heard evidence that professional courtesy was being used to justify providing priority access to care for doctors, nurses, and other health care workers and their families in emergency departments. Priority access for health care professionals to emergency department services is improper preferential access, even when calling it professional courtesy. The only exception would be priority access for essential health care workers where failure to give them priority would prevent them from carrying out their duties and would place others in danger. But any such exception should be clearly spelled out in a protocol.

Professional courtesy can and should encompass services by one physician to another physician or to other professional colleagues, such as nurses. This is not improper. However, there is no justification for labelling as professional courtesy consultations conducted as favours for friends or other contacts. Regulatory bodies have a role to play in bringing clarity to the boundaries of professional courtesy.

Recommendation 3:

Clarify the scope and application of professional courtesy

The College of Physicians & Surgeons of Alberta, working with the Alberta Medical Association, the College & Association of Registered Nurses of Alberta and other representative bodies, as well as public representatives, should closely examine the practice and ethical implications of professional courtesy with a view to defining its scope and application and providing guidelines to health care professionals.

Wait lists for medical procedures

The mandate of this inquiry was not to examine wait lists *per se*. However, wait lists and the excessive time people may wait for assessment and treatment can be important motivators for patients to try to expedite access by improper means.

In Canada, wait times are usually measured from the time of the patient's consultation with the specialist to the time of treatment. Canada has one of the narrower measures of wait times among developed countries. If the goal is to reduce the patient's total wait time, looking at the entirety of the patient's period of contact with the health care system would be more appropriate. It should also enable greater co-ordination of care throughout the patient's journey to treatment.

Alberta is tracking, benchmarking and reporting on wait times for a number of programs and services. In addition, the Alberta Wait Time Reporting System was launched on the Alberta Health website in May 2011. That reporting system shows wait time information on surgical procedures and diagnostic tests, including MRI scans and cancer services, as reported by Alberta specialists and facilities.

AHS has acknowledged the need to improve access and reduce wait times. At a minimum, AHS should consider developing a wait time measurement system that takes into account the four principal categories of waits:

- The wait to see a primary care provider;
- The wait for diagnostic tests and examinations;
- The wait to see the specialist after referral by the primary care provider; and
- The wait for treatment.

There should also be a system for tracking procedures and their health outcomes. This data would provide a much more comprehensive and patient-centred picture of the true nature of waits in the health care system.

Recommendation 4:

Reduce wait times

Alberta Health Services should continue its current efforts to improve access to health care overall and to reduce associated wait times. It should also consider implementing a comprehensive wait time measurement system.

Wait list management: In 1998 Health Canada reported that, with rare exceptions, wait lists were non-standardized, capriciously organized and poorly monitored. For some time there has been interest in standardizing data and in coordinating and integrating wait lists. Wait list management should therefore be part of any discussion about equitable access and the potential for improper preferential access.

Recommendation 5:

Develop and implement wait list management strategies

Alberta Health Services, in consultation with appropriate sectors of the health care system and the public, should develop and implement consistent and comprehensive wait list management strategies which include:

- standardized concepts and terms;
- standardized prioritization criteria, both within a given specialty and among different specialities, to better organize the allocation of shared resources (such as operating room time);
- centralized referral and booking systems;
- a system of audit and evaluation; and
- publicly accessible information on wait times, referrals and bookings, and service availability by provider (physician, clinic or hospital).

Referrals by physicians: Patients typically obtain access to specialist physicians and procedures through referrals from primary care physicians. Referrals vary greatly in quality and thoroughness. Specialists use the information provided by the referring physician to prioritize patients on their own wait lists.

Alberta Health Services is attempting to standardize the referral process for each clinical specialty and introduce a system of electronic referrals. Efforts to achieve this should continue, with physicians, program administrators and the public collaborating in all aspects of program design and implementation.

Recommendation 6:

Develop standardized referral procedures and booking systems

Alberta Health Services should continue to develop standardized referral procedures and centralized triage and booking systems to improve access and reduce referral wait times. Any such systems should be audited and evaluated, and education programs should be given to service providers about how to use new systems.

Transparency and accountability: Decision-making in health care needs to be more transparent to the public, to help the public understand how the system works and its limitations. Better public education about health care options could help alleviate some recurring pressures in the system. Most important, if the public sees that the decision-making criteria in the health care system are fair, transparency can enhance public confidence in the system.

Health literacy is also an issue. A large majority of Canadians lack sufficient health literacy to make appropriate health decisions.

Unlike in several other countries, there is no real accountability in Canada for failing to meet standards for wait times. Many countries have introduced wait time guarantees or sanctions for those health care providers who fail to meet wait time targets. These sanctions and guarantees have produced mixed results. Countries that introduced strong sanctions in conjunction with wait time guarantees had some success in reducing wait times. But there is also evidence that guarantees have led to patients being prioritized improperly.

If there are to be benchmarks for wait times or guidelines for prioritizing referrals, there must also be meaningful tools to evaluate their effectiveness. The public must be part of any discussion about such measures.

Accountability comes in part from appropriate complaint mechanisms. AHS has a process for receiving complaints from patients. The College of Physicians & Surgeons of Alberta also has a formal complaints process about professional conduct issues. The College offers a form of alternative dispute resolution where staff members, called patient

advocates by the College, are available to work with complainants and attempt a satisfactory resolution.

These complaint processes are useful but they are still internal mechanisms and do not provide the type of independent advisory or advocacy services that patients may require. In 2010, the Alberta legislature enacted the *Alberta Health Act*, but the Act is still not in force. The Act provides for the appointment of a Health Advocate to review complaints that a person working in the health care system failed to act in a manner consistent with a Health Charter.

There is merit in considering a system of independent advocates for patients in Alberta. This advocate role would complement efforts at more effective wait list management and assist in achieving equitable access.

Recommendation 7:

Consider creating the position of Health Advocate

The Government of Alberta, in consultation with Alberta Health Services and the College of Physicians & Surgeons of Alberta, should consider establishing an independent office of Health Advocate. The role of the Health Advocate would be to provide advice and advocacy assistance to patients and to help resolve patient complaints.

Alleged improper preferential access – case studies

The inquiry reviewed several possible incidents of improper preferential access. Some pre-dated the creation of AHS in 2008. The inquiry also heard about circumstances and practices that could lead to improper preferential access.

MLA advocacy

There was no evidence before the inquiry proving that any MLA used influence or other means to enhance his or her own care or that of family or friends. The inquiry heard about the type of advocacy in fact carried out by MLAs and considers such advocacy an appropriate function for elected representatives. MLAs have a responsibility to

ensure that constituents receive the level of publicly funded service they deserve.

Courtesy calls

The inquiry heard about the alleged improper preferential treatment of so-called VIP patients – politicians, health board members, donors, or their families – as well as two incidents involving the treatment of high-profile athletes. One incident involved Calgary Flames hockey players and their families receiving vaccinations at a private clinic during the H1N1 pandemic in 2009. The other involved an Olympic athlete obtaining urgent radiology services in 2011.

The evidence relating to VIP treatment generally focused on certain practices in the Capital Health and Calgary Health regions before AHS was created. These practices involved courtesy calls – also described as heads-up calls – where someone in the office of the health region CEO would call a senior administrator in a hospital facility or, if it was after hours, the executive on call that day. The caller would pass on information that a certain patient was in the facility or would seek information about the status of the patient.

The examples before the inquiry all related to the period before the creation of AHS. This suggests that this practice was never very common and is even less common now. In addition, the evidence did not reveal any improper preferential access. In no case was there evidence that the VIP who was the subject of one of these courtesy calls actually received expedited or preferential care. Still, the absence of a clearly-defined protocol on how front-line staff are to respond to heads-up calls may lead to misunderstandings.

AHS should develop a policy that clearly defines when such courtesy calls can be made, to whom they can be made and how those receiving such calls should respond to them. The policy should distinguish between calls relaying patient concerns and those alerting staff to the presence of high-profile patients.

Recommendation 8:

Develop a policy on courtesy calls

Alberta Health Services, in consultation with other sectors of the public health care system, should develop a policy on information or courtesy calls that clearly defines the circumstances under which such calls should be made, to whom they can be made, and how those receiving such calls should respond to them.

The Paula Findlay case

An Olympic athlete, the daughter of an Edmonton neurosurgeon, was in Edmonton in July 2011 for a World Cup triathlon race. The race was to be held on July 10. On July 7, the athlete had a medical problem that saw her end up at the University Hospital for magnetic resonance imaging (MRI) later that day. Her father became actively involved in arranging for the MRI and in fact wrote the requisition for his daughter to have the MRI. At issue was whether his actions led to improper preferential access to the MRI for his daughter.

The athlete clearly received preferential access over others in one sense, since she had a much shorter wait for an MRI than most people. However, that preference was based on clinical considerations – the potential of a worsened injury if not diagnosed and treated promptly. That placed her in a more urgent category than many other patients. The preference was therefore proper.

Calgary Flames and the H1N1 vaccine

In October 2009 a controversy erupted after the media reported that Calgary Flames hockey players and their families had received the H1N1 vaccination at a private facility, avoiding the lineups at the four public vaccination locations in Calgary. This episode is a clear-cut case of improper preferential access since the Flames' players, family and staff avoided the long lineups at the public vaccination clinics.

The Calgary Flames vaccination incident may have been one of a kind. Still, this problem might never have arisen if AHS had a policy on dealing with requests for special accommodations.

Recommendation 9:

Develop a policy on special accommodation during a pandemic

As part of any pandemic preparedness plan, Alberta Health Services should develop a policy on how to address requests for special accommodation.

Nurses and the H1N1 vaccine

The inquiry heard evidence about other issues arising from the H1N1 vaccination program in 2009. Some of it concerned nurses working in the Edmonton area who:

- expedited the vaccination of family members at the public immunization clinics;
- vaccinated individuals after hours;
- vaccinated individuals after the program had been halted; or
- took vaccine home to vaccinate family and friends.

The conduct of the nurses in immunizing family and friends outside of clinic hours and away from clinic premises, and expediting the vaccination of family members at clinics while nurses were on breaks, without permission from superiors, constituted improper preferential access.

Red Deer immunizations

The inquiry also heard evidence about possible improper preferential access through the H1N1 vaccination of AHS employees at their place of employment in Red Deer, rather than at a public clinic. About 100 AHS employees worked at the Michener Bend Building in Red Deer. No front-line doctors or nurses worked there, though some of the administrators were nurses. On the lower level of the building was the

Emergency Operation Centre dedicated to helping to coordinate the H1N1 vaccination program in the region.

Staff working in the Emergency Operation Centre received their vaccinations on site, instead of being forced to wait in lengthy lineups at public vaccination clinics. Other AHS personnel in the Michener Bend Building also received vaccinations on site even though they were not involved in emergency operations.

It may have been appropriate to make special efforts to immunize those working in the Emergency Operation Centre on site, but there was no justification for doing so for non-essential administrative personnel. Such vaccinations constituted improper preferential access.

Emergency care and triage procedures

The inquiry heard about possible improper preferential access involving emergency room procedures. It also heard about a practice, referred to as the private patient path, whereby emergency departments were used to facilitate access for some patients.

Emergency and triage: When patients arrive at an emergency department, they are triaged and then treated according to the urgency of the care they require.

The limited testimony before the inquiry on this subject did not disclose improper preferential access in emergency departments in Alberta. None of the witnesses provided examples of improper preferential access. The evidence consistently showed that procedures used in emergency departments – and, indeed, the professional culture of emergency personnel – serve to limit the potential for improper preferential access. The instances described, where some patients may have been attended to more quickly than they appeared to warrant, were in fact justifiable on a practical and ethical basis. There was no evidence that giving priority to the patients involved in the incidents described to the inquiry delayed the assessment or treatment of any other emergency patient.

Private patient path: The private patient path refers to the practice of physicians directing their patients to the emergency department to see them or another particular physician.

There was no evidence of any policy, system-wide or local within a facility, to regulate this practice. It was not clear from the evidence when the private patient path is acceptable and when it constitutes improper preferential access. It was also not clear why it is necessary or desirable to have a private patient path within the health care system.

An in-depth analysis of the benefits and drawbacks of the private patient path phenomenon would be useful. The analysis must, besides examining procedures, examine the ethical issues that the phenomenon raises.

Recommendation 10:

Develop policies for the private patient path

Alberta Health Services, in consultation with appropriate stakeholders, should analyze the ethical and practical implications of the private patient path and develop appropriate policies for emergency department personnel and physicians.

Colon Cancer Screening Centre

The inquiry heard testimony from 15 witnesses over several days about the alleged preferential treatment of some patients at the Colon Cancer Screening Centre (CCSC), also known as the Forzani & MacPhail Clinic. The CCSC opened in 2008. Its goal was to move screening colonoscopies from acute care facilities to the CCSC. Screening colonoscopies are those done, for example, when a person reaches a threshold age, even if the person has no symptoms suggesting the need for a colonoscopy.

The evidence on this topic was complex. Nevertheless, patterns of behaviour emerged and clearly demonstrated how procedures instituted at CCSC to ensure equitable queues for colonoscopies were bypassed for certain patients. A significant volume of evidence showed that patients of one physician and of one private clinic received much faster screening at CCSC than was the norm.

These patients received improper preferential access to CCSC screening colonoscopies. The lengthy typical waits for routine screenings were bypassed by deliberately marking these referrals as

urgent and booking the earliest appointment possible. This process violated established CCSC booking procedures.

There was no conscious effort by the private clinic's staff and physicians to circumvent CCSC booking practices. However, the end result, regardless of the lack of motive, was that the referrals sent to one physician were booked for screening sooner than the norm. This constituted improper preferential access.

The improper preferential access was facilitated in two ways: (1) by the physician giving referrals directly to an administrative assistant or a booking clerk; and (2) by the manager of the CCSC telling the clerks that arranged patient bookings to give priority to those patients.

Recommendation 11:

Strengthen access, triage and booking procedures

Alberta Health Services should put measures in place to ensure that:

- access, triage and booking procedures at each Alberta Health Services facility are clearly designated as procedures that must be followed by all medical professionals and staff members;
- staff members are trained about access, triage and booking procedures;
- senior management at each facility is trained on procedures to receive and handle staff concerns regarding non-compliance with procedures by anyone; and
- staff members are aware of the protections available under applicable whistleblower legislation and the procedures for using the legislation.

Policies on improper preferential access

The inquiry heard evidence that AHS has under consideration a draft policy on preferential access. The policy that eventually emerges should clearly describe which forms of preferential access are improper and should not be allowed, and how to respond to requests or attempts to obtain preferential access that is proper. The policy should be

disseminated to the public and health care professionals to make the AHS position clear to all.

Recommendation 12:

Develop a policy on preferential access

Alberta Health Services should complete its draft policy on preferential access, after taking into consideration this inquiry's findings and recommendations and after consultation with Alberta Health Services staff, health care professionals and the public.

The policy should clearly describe which forms of preferential access are improper and should not be allowed, and how to respond to requests or attempts to obtain preferential access that is proper. The policy should be disseminated to the public and health care professionals to make the AHS position clear to all.

Conclusion

Improper preferential access to publicly funded health services undermines the principles that access to health care should be determined by medical need and that health care should be distributed in an egalitarian manner.

This inquiry has investigated incidents that revealed improper preferential access. These incidents may not be representative of the health care system as a whole. However, they demonstrate the opportunities that may exist within the system for improper preferential access.

The inquiry has also examined various practices that may open up avenues for improper preferential access – such as professional courtesy and what has been called the private patient path. These practices could benefit from a more considered analysis, and policies about them need to be clear.

This inquiry has clearly demonstrated that myriad opportunities exist for improper preferential access. This is because of the multiple ways to access the health care system and the broad discretion regarding

management of wait lists granted to physicians, other health care professionals and administrators.

Several questions remain. Is it realistic to think that measures can be put in place to eliminate improper preferential access altogether? Are there simply too many holes to plug? What will plugging those holes cost? Even if a system could be designed to prevent improper preferential access, what would be the impact on how physicians, hospitals and clinics operate and organize their workloads? There is, after all, merit in maintaining flexibility to meet the differing needs of patients. That is why most of the recommendations of this inquiry promote collaboration among various groups interested in health care to improve policies and guidelines. The literature review conducted for this inquiry found a lack of empirical evidence on the impact of improper preferential access on the health care system as a whole. The inquiry found no evidence that improper preferential access in the cases it examined had led to harm to any patient. What improper preferential access exists in the system – apart from in areas such as workers' compensation cases, where legislation creates a system of preferential access – involves an extremely small percentage of the total cases handled in the public health care system. It is a minor phenomenon in the public health care system.

However, the perception remains that some receive faster access to health care because of status or connections, not medical need. This is just as damaging to confidence in the public health care system as the actual cases of queue-jumping identified in this report. Those who deliver health care must be prepared to challenge the perception as well as address the reality.

Acknowledgements

I wish to express my thanks to all whose work and dedication were helpful to me as I undertook my inquiry and prepared this report. In addition to those individual experts whose contributions aided me significantly, I would like to acknowledge and thank the following people in particular.

I was fortunate to retain **Sheila-Marie Cook**, **CVO**, to act as my executive director and Commission secretary. Ms. Cook brought years of experience working with several commissions of inquiry appointed by the federal government. She undertook responsibility for all aspects of our administrative needs. She retained the staff and secured the premises for our work. She served as my principal communicator with personnel in the office of the Minister of Health and with the Health Quality Council of Alberta (HQCA), as well as serving as the main media contact.

I was particularly pleased that Ms. Cook made arrangements with the Department of Policy Studies at Mount Royal University to have two students join our staff as interns. The two, **Pat Quinn** and **Jayeful Islam**, assisted the inquiry in many ways, including providing research assistance.

In the early months of the inquiry I was greatly assisted by two lawyers, **Laura Snowball**, a sole practitioner in Calgary, and **Anne Kirker**, **Q.C.**, of the firm of Norton Rose Canada. Subsequently, I appointed **Michele Hollins**, **Q.C.**, of the Calgary firm of Dunphy Best Blocksom LLP, as chief Commission counsel. Assisting her were **Jason Wilkins** as associate Commission counsel and their associates, **Ellen Embury**, **Ryan Penner**, **Gordon Sterchi** and **Saarah Shivji**.

The inquiry benefitted greatly from the work of its director of research, **John McGurran**, adjunct professor at the Dalla Lana School of Public Health at the University of Toronto.

In order to comply with the requirement for a budget monitoring system, the Commission retained the services of KPMG Chartered Accountants. Auditors **Sharlene Wilson** and **Maxime Duguay**, of the KPMG Calgary office, provided excellent service to the inquiry.

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I was assisted in the preparation of the report by **Eugene Oscapella**, a public policy consultant and solicitor from Ottawa, who brought to the task his extensive experience working on other commissions of inquiry.

I am also grateful for the assistance provided to me by **Dr. John Cowell**, Chief Executive Officer of the HQCA, and his staff.

By mentioning these people I do not want to minimize the important role played by all the people who worked on the inquiry staff and whose names are listed in an appendix to this report. My task would have been more difficult without their assistance and dedication. Again, I express my gratitude to everyone who helped to fulfill the Commission's mandate.

SECTION I: INTRODUCTION

CHAPTER ONE: REASONS FOR THE INQUIRY

Section 17 of the *Health Quality Council of Alberta Act*[1] permits the Lieutenant Governor in Council to order an inquiry concerning a matter relating to the health system when it considers such an inquiry to be in the public interest. This inquiry was established by an order in council issued on February 28, 2012. The inquiry's terms of reference were to consider:

i. Whether improper preferential access to publicly funded health services is occurring; and

ii. If there is evidence of improper preferential access to publicly funded health services occurring, make recommendations to prevent improper access in the future.

The inquiry's terms of reference did not define improper preferential access or, as it was commonly called during the inquiry, queue-jumping.

A. *A question of access*

The Canadian health care system is premised in part on the ideal of equitable access to necessary physician and hospital services without regard to one's ability to pay for those services. This ideal incorporates the principle that those with the greatest medical need should receive priority access to the system.

When I speak of equitable access, I do not mean equality of access. Both are important concepts, but the distinction between them is also important. I adopt the definitions proposed by one of our expert witnesses, Prof. John Church of the University of Alberta. He defined equality of access as "everybody should have access to health care services."[2] Equity of access he defined as "ensuring that patients who have the same medical conditions have the same opportunity to access the same services." Both equality of access and equity of access are essential pillars of health care in Canada, but the task of this inquiry has

[1] S.A. 2011, c. H-7.2.
[2] Testimony of John Church, Transcripts, vol. 39, February 27, 2013, at 3375.

been to focus on equity – whether some people are getting access, without medical justification, ahead of others similarly situated.

In the 2002 report of the federal Commission on the Future of Health Care in Canada, the Hon. Roy Romanow wrote that Canadians strongly support the core values of equity, fairness and solidarity on which our health care system is premised. He noted that Canadians consider equal and timely access to medically necessary health care services on the basis of need as a right of citizenship, not a privilege of status or wealth.[3] Yet there exists a pervasive belief that we in Canada have a two-tiered health care system, where advantage is secured not necessarily through wealth but through connections or status. In short, some believe that others get faster access to health care for reasons other than medical need. This perception is likely widespread, but evidence showing the existence of a two-tiered system is predominantly anecdotal.

The belief that some receive publicly funded services faster because of who they are or who they know corrodes faith in the claim that Canadian health care is premised on equitable access. Yet it must also be acknowledged that most people, faced with a serious medical need of their own or of a loved one, would use whatever influence or connection they could to see that need addressed as quickly as possible. This is so even if that means securing advantage – jumping the queue – over others with similar medical needs. That is human nature. And that natural tendency becomes more pronounced if there are long waits for medical attention.

Achieving timely access to care has been a priority policy goal for many years, particularly as the public has become better informed about lengthy wait times for medical procedures that are in great demand. Numerous studies have demonstrated that all provinces, including Alberta, have long wait times for many procedures despite the significant public funds spent on health care.

The *Canada Health Act*[4] states that one of the primary objectives of Canadian health care policy is to facilitate "reasonable access" to health services without financial or other barriers. But if access becomes

[3] Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada: Final Report* (Ottawa, 2002) at xvi.
[4] R.S.C., 1985, c. C-6, s. 3.

unreasonable – or publicly unacceptable – the natural inclination will be to look for ways to bypass that unreasonable and unacceptable situation.

This issue of reasonable access is neither new nor unique to Alberta. For the past decade, *Canada Health Act* annual reports have cited queue-jumping as among the most prominent concerns with respect to compliance under the Act. A 2010 survey of Albertans by the Health Quality Council of Alberta (HQCA) noted that "from the public's perspective, access – the ease of obtaining health care services – continues to be the most important factor associated with [Albertans'] overall satisfaction with health care services received."[5] Recent surveys in 11 high-income countries conducted in 2010 and 2011 by the Commonwealth Fund, a private foundation, revealed considerable dissatisfaction among Canadians with numerous aspects of provider access. The 2010 survey also revealed that Canada had among the poorest outcomes in access to a doctor or nurse, wait times for elective surgery or to see a specialist, and the highest reliance on emergency departments for care.[6]

The Commission on the Future of Health Care in Canada spoke about the importance of timely access:

> Providing timely access to quality health care services is a serious challenge in every province and territory. Consistently, the Commission heard concerns from Canadians about waiting for diagnostic tests, waiting for surgeries or waiting to see specialists. In the minds of many Canadians, the quality of our health care system should be judged, first and foremost, by its ability to provide timely access to the care people need.[7]

The Supreme Court of Canada referred to accessibility in its 2005 judgment, *Chaoulli v. Quebec*.[8] The Court noted that the *Canada Health Act* does not provide benchmarks for the length of wait times that might be regarded as consistent with the principle of real

[5] *Satisfaction and Experience with Health Care Services: A Survey of Albertans 2010* (December 2010) at 5.
[6] Gregory P. Marchildon, "Canada: Health System Review," (2013) 15:1 Health Systems in Transition at 57.
[7] Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada: Final Report* (Ottawa, 2002) at 137.
[8] [2005] 1 S.C.R. 791.

> accessibility.[9] It concluded further that a provincial prohibition on private health insurance in circumstances where the government fails to deliver health care in a reasonable manner and, by so doing, increases the risk of complications and death, interferes with the rights to life and security of the person as protected by section 7 of the *Charter*.[10]

It is not surprising that ordinary people who may be facing long waits for care become upset on hearing that others may have received expedited access. These long waits are exacerbated by the apparent lack of national or provincial standards for managing wait lists, that being left primarily in the hands of the service provider, be it a surgeon or a clinic. And this situation exists with a backdrop of anecdotes that health care professionals are routinely being approached to expedite care for politicians, sports stars, other prominent individuals and relatives of colleagues.

B. *The allegations prompting the inquiry*

This inquiry was established primarily as a fact-finding body because of specific allegations that received widespread media and political attention. It is important to restate those allegations at the outset to show the context for the inquiry's work.

The order in council establishing this inquiry did not set out any established facts or specific allegations to justify calling the inquiry. It merely contained the general comment that "allegations have been made that some individuals are, or have been, given improper preferential access to publicly funded health services." Despite the generality of this statement, the events leading to the establishment of this inquiry give a clear picture of the allegations behind the calling of this inquiry.

In June 2011, Alberta media reported on a speech given by Dr. Stephen Duckett, the former Chief Executive Officer of Alberta Health Services (AHS), at a meeting of senior health officials in Toronto on May 5, 2011. Dr. Duckett spoke about the challenges he encountered in 2009 as the first CEO of the newly-created AHS, an integrated health care system that brought together several formerly separate regional boards

[9] [2005] 1 S.C.R. 791 at para. 16, Deschamps J.
[10] [2005] 1 S.C.R. 791 at para. 124, McLachlin C.J.C. and Major J.

and health entities. One line in that speech caught the media's attention: "I'm told some of my predecessor CEOs had designated 'go-to' guys for discrete waiting list adjustments on request from MLAs, a practice I discontinued." The media also reported on a December 6, 2010, speech by Dr. Duckett, shortly after the termination of his appointment with AHS, where he said that his predecessors had "Mr. Fix-its" on staff whose role was to respond to external pressures and sometimes to manipulate wait lists.

These news stories also referred to a memo from Dr. Duckett that had been distributed to senior AHS executives on June 11, 2009. Attached to the memo was a policy document entitled "Requests for Preferential or Expedited Care." That document contained the following statement under the heading "Background":

> It is not uncommon for executive members or other leaders of health care organizations to receive requests to provide preferential or expedited care for "prominent" individuals or the family and acquaintances of "prominent" people.

These same news stories cited claims by emergency room doctors that, before AHS was created, it was common for rich and well-connected Albertans to jump wait lists for medical care.[11] Dr. Raj Sherman, the MLA for Edmonton-Meadowlark, then sitting as an independent MLA and himself an emergency room doctor, was quoted as saying that he personally received requests from hospital executives that certain patients get preferential treatment.[12]

On February 28, 2011, Dr. Sherman said in the legislature that he knew of about 1,200 Albertans who were on a wait list for lung surgery, and "250 died waiting on that list, many with lung cancer." He also stated that "physicians who raised these issues were either punished or driven out of the province or paid out in millions to buy their silence."[13]

On March 12, 2011, the Minister of Health responded by directing the HQCA to examine wait times for emergency department services and cancer care services. This direction was later amended to include a

[11] M. McClure, Tories in new health scandal, *Calgary Herald*, June 7, 2011; No hospital wait for buddies of Alberta politicians, *CBC News*, June 7, 2011.
[12] No hospital wait for buddies of Alberta politicians, *CBC News*, June 7, 2011.
[13] Legislative Assembly, *Alberta Hansard*, No. 4 (February 28, 2011) at 65 (Dr. Raj Sherman).

review of the possible intimidation of physicians who advocate in the interests of their patients. The HQCA released a comprehensive report in February 2012. The report concluded that the more inflammatory allegations about 1,200 people on a wait list for lung surgery and 250 people dying were unfounded.[14] The report did not look at preferential access and made no suggestion for an inquiry into the subject. The examination of physician intimidation focused on one aspect of that subject, intimidation directed by governments and governing bodies against physicians who advocate in their patients' interests or in the interests of communities and the population as a whole. It did not, however, examine intimidation of physicians by those attempting to secure improper preferential access to health care for themselves or others.

The controversy generated by Dr. Duckett's statements grew when the leader of the New Democratic Party in the legislature, Mr. Brian Mason, asked the Royal Canadian Mounted Police in June 2011 to investigate the allegations of queue-jumping. Mr. Mason also set up a hot-line and invited people who knew of queue-jumping to call in confidence. Mr. Mason eventually concluded that this exercise generated no information worth pursuing.

In August 2011, the RCMP announced that there would be no criminal investigation. A news article quoted an RCMP spokesperson as follows:

> "We were not able to substantiate even a single specific incident of queue-jumping," Sgt. Patrick Webb said…. "People talked about it, but no one was able to provide specifics that this actually happened. Anecdotal stories, rumours, are not enough to justify a criminal investigation, criminal charges and court proceedings."[15]

The opposition parties, however, continued to press for a judicial inquiry, one with a broad mandate. The medical profession called for a judicial inquiry into physician intimidation, something the HQCA

[14] Health Quality Council of Alberta, *Review of the Quality of Care and Safety of Patients Requiring Access to Emergency Department Care and Cancer Surgery and the Role and Process of Physician Advocacy* (February 2012) at 20, 136.
[15] T. Cook, No criminal investigation into queue-jumping in Alberta health care, RCMP find, *The Globe and Mail*, August 10, 2011.

report expressly recommended not be done. In late February 2012, after release of the HQCA report, the government established this inquiry.

Following is a detailed examination of the allegations prompting this inquiry.

(i) The Duckett allegations

Dr. Stephen Duckett was President and Chief Executive Officer of AHS from March 2009 to November 2010.

Commission counsel asked Dr. Duckett about comments he made in a farewell speech to senior AHS personnel on December 6, 2010.[16] Counsel read two paragraphs from that speech. The first paragraph, under the heading Paradise Lost?, read:

> An early challenge I faced was the issue of AHS legitimacy. When I arrived there were still many (inside and outside AHS) who lamented the demise of the predecessor entities, and they looked back on the good old days when everything was perfect.[17]

The second paragraph read:

> This perception that the predecessor entities were perfect was achieved by aggressive media management, restricting transparency, duchessing key commentators, and in some former entities, by having a "Mr. Fix-it" whose role was to respond to external pressures, including manipulating waiting lists. Unfortunately for me, these strategies were not consistent with either my values or those of AHS.[18]

Commission counsel asked Dr. Duckett to explain what he meant by a "Mr. Fix-it." He said:

> So some of the – the larger entities, and in particularly in my mind was Capital Health, had a person in the CEO's office who was sort of a go-to person, a single point of contact, if you will, for dealing with MLAs or prominent people, I guess,

[16] Exhibit 21.
[17] Testimony of Stephen John Duckett, Transcripts, vol. 4, December 4, 2012, at 288.
[18] Testimony of Stephen John Duckett, Transcripts, vol. 4, December 4, 2012, at 289.

> sometimes to fix problems. And the problems to be fixed might involve – could range across a range of areas but included preferential access is my – is what people told me. So that's what I was referring to.[19]

Counsel asked who he understood filled that role in Capital Health before the amalgamation. Dr. Duckett said it was Mr. Brian Hlus.[20] Counsel asked, "And who told you that Brian's role included arranging for preferential access?" Dr. Duckett responded:

> The number of people who told me about those sorts of roles and who told me, for example, that I should have someone who did those things, that it was to fix practically anything. So it was a criticism of me that fix-it people weren't kept in the organization.[21]

Counsel asked, "And who levelled that criticism?" Dr. Duckett said, "A number of MLAs, but amongst others that I recall is Raj Sherman."[22]

Counsel then asked, "You've said that Dr. Sherman and other MLAs registered complaints with you for having done away with this fix-it role, as you've described it. But you also said that people had told you about the range of services provided by these fix-it people, which included, to your understanding, arranging for preferential care. Who were those people that told you that that position had included that kind of conduct?" Dr. Duckett said:

> So I had discussions with a number of senior leaders within AHS over the time about how the previous organization was working and didn't work. Also, as I said, there was a lot of criticism of the lack of clarity of the organizational structure and there was a lot of – especially from MLAs who said, you know, they don't know who to go to. So I wanted to find out what was it that they went to people about. And, in general, it was about changing priorities. And the change in priorities might be all sorts of priorities. It might be they want me to spend more money on this rather than that, or it might be that there were particular people who were having problems

[19] Testimony of Stephen John Duckett, Transcripts, vol. 4, December 4, 2012, at 289.
[20] Testimony of Stephen John Duckett, Transcripts, vol. 4, December 4, 2012, at 290.
[21] Testimony of Stephen John Duckett, Transcripts, vol. 4, December 4, 2012, at 290.
[22] Testimony of Stephen John Duckett, Transcripts, vol. 4, December 4, 2012, at 290.

> getting access to the system. And that sort of example was given to me a few times, but I cannot tell you precisely which of the internal people in AHS were giving me that sort of information, nor can I tell you the MLAs who were complaining to me. But, as I said, it was a general criticism at the time that they didn't have the fix-it people.[23]

Commission counsel asked, "Sir, this go-to person or single point of contact, as you described it, you said that you understood in the Capital Health Region, at least, that that person performed a range of services. Would you agree that among those services would be the legitimate provision of advice and navigational assistance?" Dr. Duckett said:

> There are a couple of roles you can have.… So I would make a distinction between providing advice about how to navigate and even providing advice about how you might have your clinical need reassessed from actually saying we're going to change your position on a waiting list or we're going to give you a management decision which is not consistent with evidence or principles or whatever.[24]

Commission counsel then asked Dr. Duckett about the following paragraph from a speech he gave in Toronto in May 2011:

> In a large organization the decision-making paths are often unclear to outsiders. Faced with a significant budget crunch, we centralized power, taking decision-making autonomy away from local managers. This often meant that MLAs didn't know to whom to turn to obtain information (a legitimate goal) or to get fixes (not so legitimate). I'm told some of my predecessor CEOs had designated 'go-to' guys for discrete waiting list adjustments on request for MLAs, a practice I discontinued.[25]

Counsel then asked, "Sir, the reference there to "go-to guys", is that the same – a reference to the same role or position that you've just described for us previously?" He said it was a "rephrasing."[26] Counsel asked, "In this version of the speech you specifically refer to requests

[23] Testimony of Stephen John Duckett, Transcripts, vol. 4, December 4, 2012, at 291.
[24] Testimony of Stephen John Duckett, Transcripts, vol. 4, December 4, 2012, at 293-94.
[25] Exhibit 22.
[26] Testimony of Stephen John Duckett, Transcripts, vol. 4, December 4, 2012, at 295.

from MLAs. What information did you have that MLAs had made these types of requests?" Dr. Duckett said:

> Again, the same issue that people had raised with me when I was finding out about these go-to guys and the Mr. Fix-it and so on. And so it was exactly the same process. So this is just the same issue but phrased slightly differently.[27]

Counsel asked, "And do you, sir, have any knowledge, or did you at the time that you gave this speech, of specific MLAs who had made requests for preferential or expedited treatment?" Dr. Duckett said:

> No, I didn't have the names. I didn't seek the names of specific people. As I said earlier in my evidence, what I was keen to do in all of this was to stop the practice going forward. It didn't seem to me to be productive to do a witch hunt to find out who had done this in the past. It was someone else's responsibility, not mine. What was my responsibility was to ensure that the practice going forwards was an appropriate one.[28]

Counsel for AHS asked, "Now, you did reference Mr. Fix-it. I take it you never spoke to this individual?" Dr. Duckett said that was correct. Counsel asked, "And you only had hearsay or second-hand reports about what this individual might have done in a legacy organization?" Dr. Duckett said, "Yes. He wasn't working in AHS when I arrived."[29] Counsel asked, "I take it you never did or had any way to test the veracity of these hearsay allegations?" Dr. Duckett said:

> …My view was what was in the past was in the past, and it wasn't my style to try and dig up dirt from the past. It just – you know, it was not productive ….
>
> We wanted to move forward. And there was enough on our plate that, you know, why bother doing that. So what I was keen to do was to draw a line and say this is the new way of doing things. And we did that in all sorts of areas of AHS.

[27] Testimony of Stephen John Duckett, Transcripts, vol. 4, December 4, 2012, at 295-96.
[28] Testimony of Stephen John Duckett, Transcripts, vol. 4, December 4, 2012, at 296.
[29] Testimony of Stephen John Duckett, Transcripts, vol. 4, December 4, 2012, at 308.

> And we didn't – what we said was, henceforth and forward, don't do those sorts of things that were done in the past.[30]

Dr. Duckett was also asked about when he first learned about the so-called "go-to guys" or "Mr. Fix-its." He said:

> I suppose this was over a period of time. Certainly the longer I was in AHS, the more there was the criticism that I didn't have such a person. Whether I had heard about those roles before the memo or not, I cannot recall, but certainly it was a constant criticism of my style in AHS structure that we didn't have such a role.
>
> You know, there were a number of issues that were raised with me, not necessarily the waiting list manipulation ones, but other issues where MLAs or the minister or whoever would seek to have issues dealt with, I guess, outside the normal processes.[31]

When asked what he meant by normal processes, Dr. Duckett replied:

> … In most cases, despite the reputation in the media that we – essentially we had an organization, with zone vice-presidents and so on would – or vice-presidents, senior vice-presidents would make decisions within their area of delegation. And, in some circumstances, there would be lobbying to change those decisions or to influence those decisions in a particular way, not related to the preferential access necessarily, but resource allocation-type decisions. And so they're often … people wanted to have a point of influence where that influence could be channelled. We resisted that and were keen for those things to be brought up the chain because, in the context of the budget cuts we were facing for most of my tenure, we couldn't afford to allow that sort of thing to happen. Subsequently it was still an issue where resource allocation questions are preferred to be dealt with more at the senior levels of the organization just so that we could make sure our priorities were being maintained.[32]

[30] Testimony of Stephen John Duckett, Transcripts, vol. 4, December 4, 2012, at 308.
[31] Testimony of Stephen John Duckett, Transcripts, vol. 4, December 4, 2012, at 311-12.
[32] Testimony of Stephen John Duckett, Transcripts, vol. 4, December 4, 2012, at 312.

The "go-to person" named by Dr. Duckett, Mr. Brian Hlus, was also mentioned by Dr. Sherman in his testimony. He knew Mr. Hlus as the director of government relations for one of the AHS predecessor entities, the Capital Health Region. Counsel asked Dr. Sherman if he, in his role as an MLA, ever had occasion to call Mr. Hlus on behalf of any of his constituents. Dr. Sherman responded:

> Typically if I had any constituency concerns, even now today, my usual advice to my staff is [to] thank the constituent for the concern and to get their consent to advocate on their behalf if that's what they would like, and whichever department, whichever ministry, is after we got their consent, to pass the request on to the appropriate ministry and the appropriate person, whether it's a government relations person for whatever issue that the constituents were interested in having advocacy for. But I personally did not phone Mr. Hlus about constituency issues.[33]

Counsel asked, "Do you have any information, Dr. Sherman, of Brian Hlus arranging for expedited or preferential access to health care for any other MLA?" He said:

> I have no direct knowledge that any expedited care was provided, but I do have knowledge that if there were health care issues, the issues would go through the government relations people, whether it's Mr. Hlus or government relations people, people for the other health regions.[34]

The evidence before the inquiry was that Brian Hlus served as the director of government relations for the Capital Health Region from 1999 to 2008. Ms. Lynn Redford held a similar position in the Calgary Health Region until 2008. Both Mr. Hlus and Ms. Redford were called as witnesses. Both denied any involvement in adjusting or manipulating wait lists at the request of politicians or anyone else.

Mr. Hlus testified that he had never heard anyone refer to his position as a "go-to guy," "fix-it guy" or "fixer" prior to Dr. Duckett's speech and had never described himself in such terms to anyone. Furthermore,

[33] Testimony of Raj Sherman, Transcripts, vol. 12, December 13, 2012, at 843-44.
[34] Testimony of Raj Sherman, Transcripts, vol. 12, December 13, 2012, at 844.

he had no idea how Dr. Duckett formed the opinion that he might have been a person in a position to make discrete adjustments to wait lists.

Mr. Hlus described his work as in part dealing with inquiries from MLA constituency offices requesting advice on behalf of constituents. He was asked whether he would make calls to a physician or to the operating room booking staff to see if something could be done. Mr. Hlus answered "No" to both questions, and said constituency offices made no requests like that of him. He was asked whether his office received calls from constituency offices identifying someone as a prominent person in connection with any inquiries about the system. He said he had not. Asked whether any constituency offices contacted him with inquiries on behalf of MLAs themselves or their family members, he answered "No." Mr. Hlus denied ever asking anyone else to contact any health service provider directly or indirectly on behalf of Capital Health and said that he knew of no one in the Capital Health office who did so.[35]

Ms. Redford's evidence was to the same effect. Part of her duties involved providing information and assistance to MLA constituency offices. She referred to this as strictly navigational advice. She never contacted physicians or health facilities on anyone's behalf, nor was she asked to do so by anyone in a position of power or influence.[36]

Several witnesses, including past and present MLAs, also testified about their interactions with Mr. Hlus and Ms. Redford. These witnesses did not perceive the roles of Mr. Hlus and Ms. Redford to include adjusting wait lists. Instead, the witnesses saw them as facilitators, providing information to help people navigate the health care system.[37] There was no evidence from anyone that Mr. Hlus or Ms. Redford fulfilled any role beyond providing appropriate navigational advice.

The Minister of Health, the Hon. Fred Horne, also testified about Dr. Duckett's allegations. Mr. Horne was elected in 2008 and served as parliamentary assistant to the Minister of Health from 2010 until his appointment as minister in 2011.

[35] Testimony of Brian Hlus, Transcripts, vol. 10, December 11, 2012, at 668-70.
[36] Testimony of Lynn Redford, Transcripts, vol. 9, December 11, 2012, at 633-37.
[37] Testimony of Brian Mason, Transcripts, vol. 12, December 13, 2012, at 912; testimony of Harry Chase, Transcripts, vol. 13, January 7, 2013, at 980.

Mr. Horne testified that, as an MLA, he would often contact Mr. Hlus to get help for constituents seeking access to health care. Mr. Horne said that the help Mr. Hlus provided involved such matters as "getting information or navigational issues." Typically, Mr. Horne's staff would make the call to seek advice. Mr. Horne had no recollection of what arrangements were made after Mr. Hlus left his position in 2009 and AHS decided not to replace "a contact person like that" to respond to MLA enquiries.[38]

What does all this evidence demonstrate? First, it shows that Dr. Duckett was willing to make accusations about people who worked in the entities that preceded AHS without having any direct knowledge of what he was talking about. Even if he did hear some allegations that wait lists were being manipulated, he did nothing to verify that information. He did not call for any investigation. He appeared to take these allegations seriously – seriously enough to repeat them on two occasions. If he did take the allegations seriously, it seems to me that Dr. Duckett, as a leader responsible for a new organization, would have taken some steps to determine (i) who did this, to make sure that they were either no longer in the organization or were trained sufficiently about the unacceptability of the practice, and (ii) how this was done, to implement systems to prevent its recurrence. What I conclude is that if Dr. Duckett received such information, he did not consider it sufficiently important or credible at the time to take these further steps.

The second point that Dr. Duckett's evidence demonstrates is that his primary concern was not about someone in Capital Health who might have manipulated wait lists. His primary concern was the complaints he was receiving from MLAs about no longer having a single point of contact for navigational advice on constituents' issues. These points of contact – Mr. Hlus and Ms. Redford, for example – were the source for assistance in navigating the health care system, something that no one called improper and, in my view, is clearly not improper.

In conclusion, I found no evidence to support Dr. Duckett's allegations.

(ii) The Duckett memo

The two speeches by Dr. Duckett received widespread publicity. Shortly after, the media also published reports about a memo

[38] Testimony of Fred Horne, Transcripts, vol. 18, January 10, 2013, at 1507-09.

distributed by Dr. Duckett on June 11, 2009, to senior AHS executives. The subject of the memo was a policy document approved at an AHS board meeting the previous month. The policy document is worth setting out in full:

Requests for Preferential or Expedited Care

Background

It is not uncommon for executive members or other leaders of health care organizations to receive requests to provide preferential or expedited care for "prominent" individuals or the family and acquaintances of "prominent" people.

Definition

In this context, "Prominent" persons include, but are not limited to:

- Other executives and senior leaders of the health care organization
- Members of the organization's Board of Directors
- Politicians and other government officials
- Philanthropists who have previously donated to the organization or its foundations
- Individuals prominent in local or provincial society or business

Preferential or expedited care includes, but is not limited to, care that is:

- Rendered more quickly than medically indicated or required
- Rendered more quickly than the current norm of the organization
- Of a higher quality and/or is more extensive/"thorough" than the currently provided norm of the organization
- Offered at a lower cost than is the current norm (i.e. for services or equipment that are non-insured or must be purchased by the patient)

Issue

Providing preferential and/or expedited care based on societal status or personal relationship to health care executive or officials, rather than on medical indications and accepted prioritization pathways for care, creates a conflict-of-interest for the organization and an ethical dilemma for the health care executive or official receiving a request to do so. By its very nature, such a scenario:

- Represents "queue-jumping", a practice that a public health care organization cannot defend or support
- Delays or otherwise adversely affects the care of other persons awaiting or requiring care, especially when the organization has limited and inadequate capacity or resources
- Implies that not all individuals in society are considered "equal," or are entitled to equal treatment
- Suggests that the organization's current norms of care do not meet acceptable standards
- Exposes the organization to negative public and/or media opinion

Principles

- Alberta Health Services strives to provide high quality, safe, and timely care to all Albertans
- Alberta Health Services treats all clients and citizens with the same high degree of respect regardless of societal status, occupation, personal relationships, income, ethnicity, or gender

Process

- Preferential or expedited care is not endorsed or encouraged by Alberta Health Services, or any of its representatives, staff, or physicians
- Requests for preferential or expedited care must be directed to the President and Chief Executive Officer of Alberta Health

Services. Other representatives, leaders, or staff of the organization are not authorized to receive or address such requests

- However, it is acceptable for representatives, leaders, and staff of Alberta Health Services to provide advice as to how to most effectively access and navigate the provincial health care system to any individual who enquires how to do so.

This policy document was prepared by Dr. David Megran, the Senior Physician Executive at AHS in 2009 and now Executive Vice-President and Chief Medical Officer for Clinical Operations. In their testimony, Drs. Duckett and Megran disagreed about which of the two first raised the issue of preferential access and about the events that led to the preparation of the AHS policy document.

Dr. Duckett told the inquiry that Dr. Megran raised preferential access in a one-on-one meeting. Dr. Duckett recollected Dr. Megran saying that he had been approached by individuals curious about Dr. Duckett's views on preferential access. Dr. Duckett said that Dr. Megran did not name these individuals. Dr. Duckett also recollected[39] Dr. Megran saying that previous CEOs or previous leaders had accepted the practice of preferential access. Dr. Duckett later explained that although he could not verify Dr. Megran's exact words, Dr. Megran had "certainly intimated" that previous health authorities had accepted the practice. Dr. Duckett said that Dr. Megran did not detail the predecessor entities to AHS in which the preferential access issue arose. Dr. Duckett said that he told Dr. Megran that he was opposed to preferential access and that he asked Dr. Megran to draft a memo to make Dr. Duckett's views explicit. Dr. Duckett said that Dr. Megran sent the resulting draft to him by email.

Dr. Megran had no recollection of raising preferential access – or "expedited care," as he described it – with Dr. Duckett. Dr. Megran said[40] that it would be difficult for him to accept Dr. Duckett's claim that he raised the issue. This was because Dr. Megran "had no knowledge of events of expedited care occurring at the time." He said,

[39] Testimony of Stephen John Duckett, Transcripts, vol. 4, December 4, 2012, at 262-64.
[40] Testimony of David William Megran, Transcripts, vol. 3, December 4, 2012, at 170-71.

"I had no personal experience. I have no recollection of people elsewhere in Alberta Health Services alerting me to that." Dr. Megran stated that he had never received a request for preferential or expedited health care during his time at the Calgary Health Region or AHS. He testified that at the time he prepared the document, in May 2009, he had never had anyone in Calgary Health Region or AHS receive such a request and report it to him.

Dr. Megran stated that it was his recollection that Dr. Duckett asked him to draft the policy document. He explained:

> But I think the straightforward, honest answer is I have no recollection of exactly how or why he asked me, and I have no recollection that I alerted him to rumours or concerns or any information I might have had since I didn't have that kind of information with respect to expedited care being an issue anywhere in Alberta Health Services or the previous health regions.[41]

Dr. Megran had no recollection of the specific parameters that Dr. Duckett set for the memorandum, but said that it was hard to believe that Dr. Duckett did not give guidance about its length. Dr. Megran was sure that Dr. Duckett had conveyed that he wanted the memorandum to indicate that this practice was unacceptable.

Dr. Megran characterized the memorandum that he then prepared as a draft that would undergo later consultation or revision. However, it was treated as complete by Dr. Duckett.[42]

Commission counsel asked Dr. Duckett about the apparent conflict between Dr. Megran's recollection of the sequence of events and Dr. Duckett's own recollection. Dr. Duckett was asked whether it was possible that, instead of Dr. Megran first raising the preferential access issue, it was Dr. Duckett's initiative to ask Dr. Megran to draft the memorandum. Dr. Duckett stated that he was "pretty sure … I can't be a million percent sure that my memory is better than Dr. Megran's, but I'm sure … I'm pretty sure" that Dr. Megran first raised the issue. Dr. Duckett explained that this was not the sort of issue that he himself would have raised because it would not have occurred to him that "this

[41] Testimony of David William Megran, Transcripts, vol. 3, December 4, 2012, at 171.
[42] Testimony of David William Megran, Transcripts, vol. 3, December 4, 2012, at 194-95.

sort of behaviour" was happening in Alberta. He said, "… there were plenty of other things to be working on in Alberta Health Services at the time, and it just wouldn't have occurred to me that this sort of practice was happening."[43]

In my opinion, the conflict in the testimony about who first raised the issue of preferential access is not significant. It merely illustrates a profound lack of recollection about something that should have been far more memorable. This was, after all, the development of a new policy for a new organization. The fact that the process to develop this policy was not so memorable undermines the suggestion that expediting access was a common occurrence – the very phenomenon alleged by Dr. Duckett in his speeches.

The key point is that neither Dr. Duckett nor Dr. Megran had any knowledge about past wait list manipulation. They agreed that preferential or expedited care was improper and that it should not be permitted. And Dr. Duckett requested the preparation of the policy statement and instructed Dr. Megran to insert the key process point – that all requests for preferential access must be directed to the president and CEO of the organization.

Dr. Megran was asked about the first sentence of the policy document headed "Background": "It is not uncommon for executive members or other leaders of health care organizations to receive requests to provide preferential or expedited care for 'prominent' individuals or the family and acquaintances of 'prominent' people."

Dr. Megran was asked why he used the expression "it is not uncommon" if he had no personal knowledge of such requests, either during the then-short history of AHS or his earlier tenure with the Calgary Health Region. Dr. Megran could not explain his use of that expression other than to suggest that it might have been confusion on his part by not clearly differentiating between requests for preferential care, something unacceptable, and requests for information and navigational advice, something that is common and acceptable.[44]

The AHS board approved the document produced by Dr. Megran. The document appeared to generate very little discussion at the board level.

[43] Testimony of Stephen John Duckett, Transcripts, vol. 4, December 4, 2012, at 266-67.
[44] Testimony of David William Megran, Transcripts, vol. 3, December 4, 2012, at 171-73.

Minister Horne testified that he first became aware of the Duckett memo through the media. He said he had no awareness of preferential or expedited access as an issue in any of his government positions. When the memo became public, there were general discussions about it within the health ministry, but nothing of a formal nature. There were no inquiries or investigations initiated by the government as a result of the memo or the other allegations levied by Dr. Duckett.[45]

Those witnesses who were leaders and staff of AHS or former entities testified about their awareness of and reaction to the Duckett memo. Their evidence was consistent that the Duckett memo provided clarity and direction to the staff since there had been no policies on the issue previously. It was welcomed by staff and supported as a statement of principle. There was, however, little discussion about it since this was not something that concerned people, particularly as it was not within their knowledge or experience.[46]

In 2011, Dr. Duckett claimed to have put a stop to the practice of manipulating wait lists through the use of "go-to guys." The 2009 policy statement specifically directed that all requests for preferential or expedited care be directed to him. During his testimony, Dr. Duckett was asked if, between the time he distributed the policy statement and his departure from AHS, he had received any such requests. He answered "No."[47]

(iii) The Sherman allegations

On June 7, 2011, Dr. Raj Sherman, formerly a Progressive Conservative MLA but then sitting as an independent, gave two interviews. One aired on CTV[48] and the other on CBC.[49] In the CTV interview, he said that he "saw it first-hand," as an emergency room physician, that people were moved up on wait lists. He claimed that for patient confidentiality reasons it was inappropriate for him to name anybody. In the CBC interview, he said he personally experienced

[45] Testimony of Fred Horne, Transcripts, vol. 18, January 10, 2013, at 1519-21.
[46] Testimony of Brian Holroyd, Transcripts, vol. 6, December 5, 2012, at 426; testimony of David Shawn Diamond, Transcripts, vol. 7, December 6, 2012, at 448-49; testimony of Deborah Gordon, Transcripts, vol. 7, December 6, 2012, at 486; testimony of Kathy Taylor, Transcripts, vol. 8, December 10, 2012, at 516; and testimony of Lynn Redford, Transcripts, vol. 9, December 11, 2012, at 632.
[47] Testimony of Stephen John Duckett, Transcripts, vol. 4, December 4, 2012, at 303-04.
[48] Exhibit 59.
[49] Exhibit 60.

requests from hospital executives for certain patients to get preferential treatment. He added, however, that no one in critical condition was ever denied treatment because a queue-jumper was getting medical help.

When questioned, Dr. Sherman admitted that he had no first-hand knowledge of these allegations, stating that he had not called for an inquiry into improper preferential access because his information was based on hearsay and anecdotes. He admitted that he did not experience or see for himself any of the matters he mentioned. He said he based his comments on his conversations with others.[50]

In his testimony, Dr. Sherman referred repeatedly to a conversation with Dr. Paul Parks (now the chief of emergency medicine at Medicine Hat Regional Hospital) as the source of his information:

> Those are comments based on the conversation I had with Dr. Paul Parks. In fact, hardly anybody could get into care in … time. So Dr. Parks and I had a good chat. Before I did that interview, I said, "Paul, does this happen in your department?" Those comments were based on the conversation that I had with Paul. Paul did not give specific cases, but he said, "Hey, this is happening in our department." So that's what I was referring to.[51]

Prior to going to Medicine Hat, and until mid-2009, Dr. Parks was an emergency physician at the University of Alberta Hospital. When he testified, Dr. Parks was not specifically asked about any conversations he may have had with Dr. Sherman or information he may have given to Dr. Sherman. This may in part be due to the fact that Dr. Parks testified before Dr. Sherman and counsel were not aware of what Dr. Sherman would say. However, Dr. Parks was asked for any examples of improper preferential access or requests for such access after 2007. (Dr. Parks earlier testified about one incident that occurred that year.) He too could not provide examples from his personal knowledge. He said:

> So, again, none that I've specifically been involved in or that I was present for. I've heard of some general examples in my

[50] Testimony of Raj Sherman, Transcripts, vol. 12, December 13, 2012, at 850-52.
[51] Testimony of Raj Sherman, Transcripts, vol. 12, December 13, 2012, at 851.

> role as the section president of emergency medicine, but, in reality, I think, as far as I'm aware, there was a cease-and-desist order by Dr. Duckett in AHS.
>
> And as far as I know, in my own view, as much as I know, I don't know that it's still going on or that there is access. But prior to this, and in this time frame, I was aware of things happening, but it would be in the general sense that someone would be in the department, but I never took note of the details or knew any specifics.[52]

Dr. Sherman also referred to informal conversations – "the type of chatter that can happen in a lunchroom" – with health care workers as the source for one of his claims about government officials receiving preferential treatment.

Dr. Sherman referred to an incident involving the treatment of Ralph Klein while he was premier at the emergency department of an Edmonton hospital in 1997 or 1998. Dr. Sherman believed that, while his own 92-year-old patient with broken bones was denied admission because there was no room, Mr. Klein was admitted and also received some pain treatment while waiting.[53] Dr. Sherman admitted he did not see this first-hand but heard about it from another emergency room doctor, Dr. Terry Sosnowski. Dr. Sherman acknowledged he had no personal knowledge of Mr. Klein's injury, did not review his chart and knew nothing about how long the premier waited to be seen, his triage score or his treatment.[54]

Dr. Sosnowski was not called as a witness and so gave no evidence about this incident. Dr. Sherman, however, also referred to his knowledge of this incident being based on "general conversations amongst the staff."[55]

The next example Dr. Sherman gave involved a call from then-MLA Mr. Thomas Lukaszuk one Friday evening in the fall of 2009. Mr. Lukaszuk, who also testified about this incident, said someone who had been physically assaulted contacted his office. He was concerned because the patient and her family were illegal immigrants and did not

[52] Testimony of Paul Parks, Transcripts, vol. 5, December 5, 2012, at 388.
[53] Testimony of Raj Sherman, Transcripts, vol. 12, December 13, 2012, at 808.
[54] Testimony of Raj Sherman, Transcripts, vol. 12, December 13, 2012, at 811-12.
[55] Testimony of Raj Sherman, Transcripts, vol. 12, December 13, 2012, at 809.

have Alberta Health Care Plan Insurance coverage, so he called Dr. Sherman. Dr. Sherman said the woman should be taken to the emergency department, explaining that no one would be turned away at an Alberta emergency department based on an inability to pay.

Dr. Sherman testified that he reluctantly agreed to meet Mr. Lukaszuk at the hospital. One of the reasons for that reluctance was the possible perception that, as a physician and a recognizable elected official, he was there to obtain preferential treatment for somebody.[56] However, he confirmed that Mr. Lukaszuk did not ask him to intervene in the patient's care or speed up her treatment in any way.[57]

Dr. Sosnowski was on shift in the emergency department that evening. He confirmed in an affidavit filed with the inquiry that neither Dr. Sherman nor Mr. Lukaszuk requested any preferential or expedited treatment for this patient.[58]

It is pertinent to ask what the point is of bringing this particular incident before the inquiry since nothing untoward happened. I do not draw any conclusions as to Dr. Sherman's motive in doing so. Dr. Sherman appeared to be most concerned about the request for his attendance at the emergency department. Counsel asked, "So what was your conclusion as to why your personal attendance was requested?" He said, "Well, my concern after – was whether my presence would expedite care. That was a concern. It wasn't expressed by Mr. Lukaszuk, but I felt like I might have been duped."[59]

Mr. Lukaszuk, in his testimony, said he contacted Dr. Sherman to get some advice and Dr. Sherman volunteered his assistance. He claimed that Dr. Sherman suggested the facility where he should take the patient. Mr. Lukaszuk said, "He offered his help, and I was very grateful for it."[60]

Counsel asked Mr. Lukaszuk if he called Dr. Sherman that evening in order to seek faster or better treatment for the patient than might be the case if Dr. Sherman was not involved. Mr. Lukaszuk replied:

[56] Testimony of Raj Sherman, Transcripts, vol. 12, December 13, 2012, at 817-18.
[57] Testimony of Raj Sherman, Transcripts, vol. 12, December 13, 2012, at 819-20.
[58] Testimony of Raj Sherman, Transcripts, vol. 12, December 13, 2012, at 861.
[59] Testimony of Raj Sherman, Transcripts, vol. 12, December 13, 2012, at 861.
[60] Testimony of Thomas Lukaszuk, Transcripts, vol. 25, January 16, 2013, at 1976-77 and 1982.

> Let me answer this in two ways. The first answer is no, and the second part of this answer would be I had no reason to do so. This person was in no way related to me. This person was not a voter, nor a constituent. It was a random person not affiliated in any way to me or my office who just presented herself in my office with this unusual circumstance.[61]

The third instance cited by Dr. Sherman was an email he received in June 2011 from Mr. Dennis Loughlin, alleging that Mr. Lukaszuk had helped a woman known to Mr. Loughlin receive expedited surgery.[62] An employee at Dr. Sherman's constituency office tried to confirm the details with the woman but she refused to speak with him and then reported the call to Mr. Lukaszuk's office. Mr. Lukaszuk raised the call with Dr. Sherman, demanding an apology. Mr. Lukaszuk, in his testimony, denied any involvement with the constituent named in the email in accessing health care on her behalf[63] and in fact denied ever contacting a health care provider in order to advocate for a constituent.[64]

Dr. Sherman drafted a memo about this incident to the Ethics Commissioner, Mr. Neil Wilkinson,[65] but Mr. Wilkinson testified that his office had no record of receiving it.[66] The memo that Dr. Sherman drafted to the Ethics Commissioner contained the following statement:

> Unfortunately, this is not the only allegation of this nature being made against the honourable Member. I have first-hand knowledge [of] an incident, the details of which I would be willing to discuss with you in confidence.[67]

Mr. Lukaszuk did not know which incident Dr. Sherman meant.[68] If his memo did go to the Ethics Commissioner, there was no evidence of Dr. Sherman passing on any other information. At this inquiry, Dr. Sherman did not share any such information and I can only conclude that he has none.

[61] Testimony of Thomas Lukaszuk, Transcripts, vol. 25, January 16, 2013, at 1984-85.
[62] Exhibit 54.
[63] Testimony of Thomas Lukaszuk, Transcripts, vol. 25, January 16, 2013, at 1990.
[64] Testimony of Thomas Lukaszuk, Transcripts, vol. 25, January 16, 2013, at 1992-93.
[65] Exhibit 55.
[66] Testimony of Neil Rudell Wilkinson, Transcripts, vol. 18, January 10, 2013, at 1487.
[67] Exhibit 55.
[68] Testimony of Thomas Lukaszuk, Transcripts, vol. 25, January 16, 2013, at 1995.

Finally, Dr. Sherman provided evidence regarding the care of his own father at the University of Alberta Hospital emergency department on February 15, 2008. On February 22, 2008, Dr. Sherman sent Ms. Sheila Weatherill (the Capital Health CEO) an email about the extremely long wait in the emergency department. It also stated:

> My main concern lies in the fact that someone (unknown) called and asked him [Sherman's father] to be moved up in the queue, in front of other patients. Had this not happened, he likely would not have survived as his wait likely would have been 7-9 hours.[69]

Dr. Sherman was unable to identify who called to ask that his father be moved up in the queue. I find it curious, however, that in his draft memo to the Ethics Commissioner, Dr. Sherman makes reference to his father's suffering, but says that he "refused to accept preferential treatment."

In the end, it is not very productive to sort through the many inconsistencies in this evidence. The conclusion I draw is that, like Dr. Duckett, Dr. Sherman was quick to make allegations about which he had no personal knowledge or documentation. It appears that his only first-hand experience with preferential care is the treatment received by his father in 2008, and the treatment he gives to his MLA colleagues in his office, something that will be discussed later in this report.

I have no doubt that Dr. Sherman is a compassionate and caring physician. He is obviously concerned about the state of the health care system in Alberta. But no facts have been presented at this inquiry to allow me to substantiate any of his allegations.

The result is that the allegations that prompted this inquiry have not been proven. And it is clear to me that if a modicum of effort had been put into investigating these allegations when they were first made, their lack of substance would have become readily apparent.

I do not say that the type of conduct alleged could not happen. Members of the legislature may very well try from time to time to exert their influence, which in turn may lead some front-line staff to feel pressure to accommodate their demands. But there was no evidence of

[69] Exhibit 58; Testimony of Raj Sherman, Transcripts, vol. 12, December 13, 2012, at 837-38.

that happening now or back when these allegations were made. Gossip, rumour, hearsay – or "lunchroom-type chatter" as Dr. Sherman described it – are not evidence.

C. *The inquiry's role*

It is not for me to comment on the arguments for or against establishing this inquiry, or its specific terms of reference. Those are obviously matters of some controversy. But this brief overview should reveal the fundamental difficulty that confronted this inquiry.

The impetus for calling the inquiry was allegations by Dr. Duckett of a system whereby political insiders were able to manipulate wait lists for necessary medical services. Yet when Dr. Duckett testified during the earliest days of this inquiry's public hearings, he admitted he had no first-hand evidence to support his allegations. He could not identify any instance of preferential treatment. Similarly, Dr. Sherman acknowledged in his testimony that he also had no first-hand evidence to support his claims. He could not identify a single incident of preferential access to health care. The senior AHS executive who authored the policy document attached to Dr. Duckett's June 2009 memo, Dr. David Megran, testified that he knew of no instances of preferential care.

Understandably, the testimony of Drs. Duckett, Sherman and Megran led the media to question the value of this inquiry. As one commentator put it, "Sadly, the careless way Duckett levelled his unsupported accusations, without evidence or foundation, means that the inquiry itself has lost its own foundation, and much of its credibility, at its very start."[70]

This is a perceptive comment. It reminds us that this inquiry sprang from certain allegations and that, once those appeared to be unfounded, people naturally questioned continuing this time-consuming and expensive process. But the inquiry's terms of reference did not limit it to examining just those allegations about political insiders. The inquiry was called to examine whether improper preferential access is occurring anywhere within the public health system.

[70] P. Simons, $10-million queue-jumping inquiry off to troubled start, *Edmonton Journal*, December 6, 2012.

Even though the allegations that led to this inquiry quickly proved to be without substance, evidence of other activities and attitudes within the Alberta health care system warranted investigation. This inquiry's terms of reference were broad enough for it to explore whatever kind of preferential access may be occurring within the health care system. The terms of reference offered the opportunity to examine an issue that has significant ethical and practical implications, yet one that has been inadequately studied. Such a study would be particularly important, given the likely perception that improper preferential access occurs throughout the health care system in Alberta and elsewhere in Canada.

It is possible to look at preferential access issues at a macro level, focusing for example on the divide between urban and rural populations in access to health care, what is and is not covered by provincial health care programs, and growing income inequality and its repercussions in health care. Doing a macro-allocation analysis would reveal disparities in any system.

But this inquiry was asked to conduct a fact-finding exercise on a micro level – for example, looking at who will be next in line for surgery and how they get there.[71] This micro-level exercise might lead to conclusions and recommendations useful on a broader, societal level. While some of the specific incidents examined during this inquiry may not be representative of the health care system as a whole, they may well illustrate some of the kinds of problems to be found within the system.

Research on preferential access as a systemic issue is very limited and most of the information available is anecdotal. As a result, it became necessary for the inquiry to examine specific incidents to see if patterns emerge. A specific instance of preferential treatment may be a one-off, not amenable to or meriting policy intervention. On the other hand, several instances may indicate systemic problems – overtly or tacitly accepted – that may warrant regulation or attention through policy measures.

This inquiry faced a difficult task. Unlike other inquiries preceded by a specific event, this inquiry had as its starting point bare, unexamined and untested allegations reported by the media. There had been no preliminary investigation into those allegations – no legislative

[71] Testimony of Owen Heisler, Transcripts, vol. 39, February 27, 2013, at 3374.

committee hearing, for example, to test statements made in the legislature. And, of course, even if there were instances of improper preferential access, there would be little likelihood of an accompanying paper trail.

The work of this inquiry was even more difficult to pursue because there is very little empirical evidence showing improper preferential access to health care. As one of this inquiry's researchers, Dr. Nishan Sharma of the University of Calgary, stated in a review of academic literature on the subject:

> Even as the popular media highlight well-publicized incidents of individuals "jumping the queue", the academic literature does not provide any evidence-based proof of preferential access that might be targeted by anti-queue-jumping measures. The studies cited that fit within the scope of this review are based on surveys, opinion and subjective data. At this point, it would be difficult to design and implement a means to limit preferential access that could be backed up with "before and after" and data to confirm the efficacy of the strategy.[72]

Commission counsel interviewed more than 150 people during their investigations. The inquiry received hundreds of emails, letters and telephone calls from the public. Whatever the source of the information, Commission counsel pursued the lead. Not all information was relevant and in some cases it related to issues beyond the inquiry's mandate. Some information was not sufficiently reliable to merit extensive examination. Many witnesses, even though called to testify under oath, exhibited a regrettable failure to recollect events and activities that should not have slipped so easily from memory. In total, 68 witnesses testified, generating over 3,700 pages of transcripts. There were 172 exhibits totalling another 1,700 pages. Ten parties presented written submissions at the end of the hearings.

Is improper preferential access occurring? This inquiry has uncovered instances where it is. Is there evidence that anyone has been medically harmed by such instances? This inquiry uncovered no specific evidence of this. It would be almost impossible in any event to show that

[72] Nishan Sharma, *Academic Literature Review of Preferential Access to Healthcare in Canada: A Report to the Health Services Preferential Access Inquiry of the Province of Alberta* (November 2012) at 14.

preferential access given to one person specifically harmed another – that is, short of actually seeing a patient bumped to make way for someone with the "right" connections.

The more significant question is whether improper preferential access causes harm to the principles underlying publicly funded health care in Alberta. It is my hope that the efforts of those involved with this inquiry have shed light on an important issue and that our recommendations lead to measures that will justify public confidence in the equity of our health care system.

CHAPTER TWO: THE INQUIRY'S MANDATE

A. *The terms of reference*

A commission of inquiry owes its existence to the order in council creating the inquiry and the terms of reference that set out the scope of the inquiry's work. The terms of reference define an inquiry's jurisdiction. However, it is my responsibility as commissioner to interpret those terms of reference.[73]

Order in Council 80/2012 contained the following preamble:

WHEREAS:

- Allegations have been made that some individuals are, or have been, given improper preferential access to publicly funded health services;
- Access to publicly funded health services is properly based on patient need and the relative acuity of a patient's condition;
- It is improper to gain access to publicly funded health services through threat, influence or favour;
- It is in the public interest to assure Albertans that the publicly funded health care system provides for fair and appropriate access to health services; and
- The Lieutenant Governor in Council considers it to be in the public interest that a public inquiry be held to make recommendations to prevent the possibility of any person being given improper preferred access to publicly funded health services.

And the order in council directed as follows:

> Pursuant to section 17 of the *Health Quality Council of Alberta Act*, the Lieutenant Governor in Council orders that a public inquiry be held concerning the possibility of improper preferential access being given to publicly funded health

[73] Ed Ratushny, *The Conduct of Public Inquires: Law, Policy and Practice* (Toronto: Irwin Law, 2009) at 141.

> services and, specifically, the terms of reference for the inquiry shall be to consider:
>
> 1. Whether improper preferential access to publicly funded health services is occurring; and
> 2. If there is evidence of improper preferential access to publicly funded health services occurring, make recommendations to prevent improper access in the future.

The terms of reference should speak for themselves. This does not, however, prevent consideration of the background circumstances that led to the establishment of the inquiry.

In Chapter 1, I highlighted the allegations made by Drs. Duckett and Sherman, as reported in the media in 2011, and the allegations in the memo distributed by Dr. Duckett in 2009 entitled "Requests for Preferential or Expedited Care." The inquiry's terms of reference did not mention these specific allegations. The preamble of the order in council merely contained the general statement that "allegations have been made that some individuals are, or have been, given improper preferential access to publicly funded health services." But it is reasonable to conclude that the allegations are those reported in 2011. It was therefore reasonable to consider those allegations as falling with the ambit of the inquiry's work even though they relate to conduct that occurred several years ago, even before the creation of Alberta Health Services (AHS) in 2009.

The terms of reference are very general. The inquiry is to consider the "possibility of improper preferential access being given to publicly funded health services." This suggests a mandate to review systems, policies, procedures and prevailing attitudes. Specifically, the inquiry was mandated to consider "whether improper preferential access to publicly funded health services is occurring." This demands a fact-finding exercise, investigating specific incidents – incidents that are not mentioned in the order in council, but ones that that may come to light as part of the inquiry's investigations.

B. *Scope in time*

The use of the verb "is" in "whether improper preferential access … is occurring" has proved particularly controversial. When the inquiry was

first announced, much of the media coverage – as well as opposition politicians and the medical community – criticized the terms of reference as unduly limiting the scope of the inquiry's work. They complained that the inquiry could only examine current queue-jumping, not past incidents.[74]

This necessarily led to arguments during the hearings about how far back the inquiry should look in its work.

Three of the four interveners – the Government of Alberta, AHS and the Alberta Medical Association – took the position that use of the phrase "is occurring" limited the evidentiary scope of the inquiry to current policies and procedures, and generally to events occurring after the creation of AHS. That seemed to be the commonly held cut-off point for these interveners and coincided with the creation of Dr. Duckett's 2009 memo. A particular concern of these interveners (and of counsel representing some witnesses) was that going back earlier than the creation of AHS in 2008 meant bringing in evidence from people who were involved in entities that no longer exist and who may no longer be playing an active role in the health care system. This evidence, it was argued, could not be relevant to what may or may not be occurring in the current system, especially since practices and procedures are constantly evolving.

The fourth intervener, the Consumers' Association of Alberta, argued for a liberal interpretation of any temporal limit. Its counsel submitted that information about past events can give a context for what may be currently happening and could inform any recommendations I might make.

Commission counsel Michele Hollins, in her submissions on this point, noted that the words "is occurring" cannot literally mean "contemporaneously." Otherwise, there would be a very narrow window within which to examine practices. So if it does not mean contemporaneous, it must mean a period with some flexibility built into it. And the test of how flexible it may be is relevance.

[74] See, for example, R. Bell, Alberta docs say health care probe doesn't go far enough, *Calgary Sun*, February 29, 2012; D. Braid, Throw away the rule book for health care inquiry, *Calgary Herald*, March 1, 2012; an editorial, headlined Examining the past: Scope of health care inquiry seems too restricted, *Calgary Herald*, March 1, 2012.

When confronted with deciding where to begin, Commission counsel quite rightly started with the 2009 Duckett memo. That was appropriate because the allegations that prompted the creation of this inquiry dated back to that time, when Dr. Duckett took over as CEO of AHS and claimed to have put a stop to political manipulation of wait lists. But, as Commission counsel noted, because AHS was itself a newly created body at the time, counsel examined both the periods before and after the creation of AHS to understand the concerns that precipitated that memo.

I do not know how one can examine the possibility of improper preferential access without looking at incidents in the past and present. This inquiry is of a type that can best be described as a mixed investigative/advisory one. The essence of such a type of inquiry lies in examining past events to determine whether current practices or legislation are adequately addressing systemic problems. As one noted expert, Mr. Simon Ruel, has written:

> In many cases, a public inquiry will be mandated to address both aspects, namely to investigate and report on a factual situation, together with making related policy recommendations for change. Such public inquiries will be both looking back and looking forward. Those mixed investigative and policy inquiries may, at the same time, assess a factual situation, review institutional policy and practices, address systemic problems and look at the adequacy of legislation and regulations.[75]

There is no question that the words "is occurring" are important and must be given a rational meaning. They provide a temporal framework. But I think it fair to say that all the participants in this inquiry recognized that the terms of reference are sufficiently broad to allow a wide temporal scope for the evidence. To determine whether something is occurring requires me to determine if something has occurred and whether the circumstances under which it occurred are continuing. However, engaging in a historical review would stretch the bounds of the terms of reference unreasonably. Commission counsel had to draw to some extent on past events to illustrate patterns of behaviour or types of systems. Those events may or may not continue now but they may still be relevant to the question of the "possibility of improper

[75] Simon Ruel, *The Law of Public Inquiries in Canada* (Toronto: Carswell, 2010) at 7-8.

preferential access being given." In a broad sense one can say that this evidence of past events and behaviours helps advance this inquiry's work.

The answer does not lie in setting some artificial cut-off date and saying that evidence preceding that is of no relevance at all. Instead, the answer lies in weighing the evidence for its cogency and probative value. The further back an incident occurred, the less weight it will have in helping to assess the current situation. And, if something occurred in the past and there is evidence that it is not occurring now, it may be useful as an object lesson in what could happen. However, it is otherwise of little use in identifying recommendations for the future.

C. *Scope in scale*

The other aspect of this inquiry's mandate worth noting is its limited scope vis-à-vis the health system as a whole. This was emphasized by all parties, but in particular in the submissions of the AHS as intervener. The publicly funded health care system is extremely large and complex. Health services are provided and received through a complex variety of pathways. Access issues may arise at numerous points: seeing a general practitioner; referral to a specialist; diagnostic measures; specialized medical services such as surgery; emergency room assessment and treatment.

It is also necessary to consider the volume of services provided. The final AHS submission provided examples of the numbers of individuals and services involved:

- Between September and December 2012, some 521,914 emergency department visits took place province-wide;
- In 2011-12, there were nearly 200,000 urgent care service visits among the six urgent care centres that were operational at the time;
- An estimated 250,000 main operating room procedures occur in AHS annually;
- Some 2,370,568 diagnostic imaging procedures (MRI, CT and X-ray examinations) were performed province-wide by AHS in 2011-12, including 166,645 MRI examinations;

- The system oversaw 547,093 cancer patient visits in 2011-12; and
- Over 350,000 patient discharges took place in AHS hospitals in 2011-12.[76]

However, this inquiry was not authorized to review the health care system comprehensively. Nor was it charged with trying to determine theoretically how improper access could be gained to different parts of the system. There are other and better vehicles for such analyses, such as the Health Quality Council of Alberta.

This inquiry was asked to look at a narrow aspect of this massively complex system. Specifically, the inquiry was to engage in a fact-finding exercise to determine if improper preferential access is occurring. As noted earlier, the Duckett and Sherman allegations had no facts to support them. But other incidents came to light and the only way to conduct the fact-finding was to examine those incidents. These incidents obviously provided a narrow glimpse of only certain parts of this complex health care system. Still, as I said previously, these examples may not represent the system as a whole, but they may be illustrative of problems that could arise in different parts of the system.

Nevertheless I recognize, as a number of the interveners have reminded me, that I have seen only a very limited picture of the overall health system in this province. Drawing broad conclusions from what may be isolated instances of improper preferential access risks leading to inappropriate recommendations for the system as a whole. I must therefore take this limitation into account when formulating my findings and recommendations.

D. *Wait lists*

This inquiry's terms of reference do not mention an examination of wait lists. However, one cannot overlook that the very existence of wait lists, and the excessive time people may wait for assessment and treatment, can be important motivators for attempting to expedite access by improper means.

Wait lists are a fact of life in Canadian health care due to the constantly increasing demand for services, coupled with a limited supply of those

[76] Closing Submissions of Alberta Health Services, April 1, 2013, at 7-8 (Exhibit 164).

services. So it is also accurate to observe – accurate but trite – that if there were no queues there would be no need to examine queue-jumping. Clearly, wait lists for necessary medical services are serious organizational issues that merit a multi-pronged attack. In part, this means examining the allocation of resources and how the health care system is managed. It also means discussing wait times and wait list management to some extent in this report, even though this inquiry was not established to focus on these issues.

E. *The issue of inferior access*

This inquiry is focused on whether people are getting improper preferential access to publicly funded health care. In other words, are people getting access that is superior to the norm? The events leading to the establishment of this inquiry, along with its terms of reference, meant that it did not focus on the other side of the preferential access issue: systemic barriers and discrimination that may result in access that is inferior to the norm. In both cases – preferential access and inferior access – the result detracts from the ideal of equitable access at the core of Canada's approach to publicly-funded health care.

I readily acknowledge that an examination of systemic or discriminatory barriers is not within this inquiry's mandate. But I would be doing a disservice if I did not at least emphasize that, for many in Alberta, the prevailing norm of access is superior to what they can hope to receive. That norm of access, when it is beyond the reach of some populations, becomes a type of preferential access in their eyes.

In its submission, the Consumers' Association of Alberta argued that barriers to access to publicly funded health services are equal to if not more deserving of examination than preferential access. Several groups can be identified as facing some discrimination or systemic barrier to access in Alberta:

- Rural populations;
- Individuals without family doctors, particularly individuals with complex medical issues;
- Individuals with addictions and/or mental health issues;
- The poor;

- The elderly;
- Individuals whose first language is not English;
- Those with hearing or vision loss or mobility issues; and
- First Nations communities.

What leads to inferior access? There may be systemic issues such as the allocation of resources – as may be typified by the situation of the members of the Rimbey and Area Renal Dialysis Support Group, who argued that rural residents have inferior access to health care. Inferior access could also flow from discrimination against a particular group in society – dependent users of alcohol and other drugs or the mentally ill, for example.

Generally, there is a strong correlation between socio-economic status and health outcomes: the lower the status, the poorer the health outcomes. There is also considerable evidence in Canada of a relationship between socio-economic status and health care utilization. The lower the income and education level of individuals, the more likely they are to use health services at the primary level, while those with higher income and education levels tend to make greater use of specialist services.[77]

The Organisation for Economic Co-operation and Development (OECD) conducted a multi-country health policy review that included Canada. It found that even in public health care systems such as ours, there are inequities in access due to socio-economic status. Individuals with higher income and education tend to wait less time for publicly funded hospital care than the less well-off and less well-educated. The report identified some possible explanations for this:

> Individuals with higher socioeconomic status may engage more actively with the system and exercise pressure when they experience long delays. They may also have better social networks ("know someone") and use them to gain priority over other patients, and they may have a lower probability of missing scheduled appointments (which would increase the waiting time). This negative gradient between waiting time

[77] W. McIsaac, V. Goel and C.D. Naylor, "Socio-economic status and visits to physicians by adults in Ontario" (1997) 2 *J Health Serv Res Policy* 94.

> and socioeconomic status may be interpreted as evidence of inequity within publicly funded systems and suggests that waiting lists may be less equitable than they appear.[78]

The submission by the Rimbey and Area Renal Dialysis Support Group highlighted the barriers to access and the consequences confronting rural populations:

- Urban planning has dominated the planning of rural health care programs, to the detriment of rural populations. The predominance of urban approaches meets the needs of large hospitals in major urban centres, but does not meet the needs of rural communities.
- The centralization of health services and rural hospital closures has had a severe impact on rural residents.
- If rural residents require more specialized care they must travel longer distances and incur additional expenses that are not fully reimbursed. During some parts of the year, travel may be impossible due to weather conditions, leading to poor health outcomes.
- Rural residents have lower health status than urban residents, higher overall mortality rates and shorter life expectancies, as well as higher rates of long-term disability and chronic illness. Rural Canadians are limited to a smaller range of health providers.
- The most serious problem for residents of rural and remote areas is access to the health care services they need closer to their own communities.
- If rural patients cannot gain adequate access to non-emergent (routine) and frequently required health care services such as renal dialysis, they face the prospect of having to sell their homes and move to an urban centre, as has been the case for numerous rural families. Having to leave communities and community networks imposes both financial and social costs on individuals, their families, their friends and their community. If one partner dies after relocation to an urban

[78] L. Siciliani, M. Borowitz and V. Moran, eds., *Waiting Time Policies in the Health Sector: What Works?*, OECD Health Policy Studies (OECD Publishing, 2013) at 29.

> setting, the other partner is often left isolated because of lost connections to their rural community.[79]

I commend the Rimbey submission for the careful consideration of the government and AHS. It can be a useful resource in developing rural health initiatives to provide equity in both access to health care and in health outcomes.

The Romanow report also gave prominence to access to publicly funded health services in rural and remote areas and made several recommendations.[80] It did the same for Aboriginal health issues, calling the disparities between Aboriginal and non-Aboriginal Canadians – both in their overall health and their ability to access health care services – unacceptable.[81] How much or little has been done since the Romanow report to address these concerns is beyond my mandate to examine.

These examples of what I call inferior access are prevalent in Alberta and across Canada. Indeed, they pose much bigger challenges to attain and preserve an equitable public health care system than does improper preferential access. Examining improper preferential access was this inquiry's task. It is not within my mandate to make recommendations about how to allocate resources to redress inferior access to health care. But I can quote from a 1998 article and endorse its message: "Implementing measures to provide better care for the socially or geographically disadvantaged may be more feasible and constructive than enforcing rigid rules to impede preferential access for advantaged persons."[82]

I recognize that in a country as large as Canada, and a province as large and diverse as Alberta, there may always be some disparities in the distribution of resources and people's ability to access them. However, I cannot submit this report without pointing to the need to acknowledge

[79] Exhibit 152, Rimbey and Area Renal Dialysis Support Group, *Submission to the Alberta Health Services Preferential Access Inquiry*, February 27, 2013 (prepared by Dr. John Church).
[80] Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada: Final Report* (Ottawa, 2002) at 159-69.
[81] Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada: Final Report* (Ottawa, 2002) at 211-31.
[82] D.A. Alter, A.S. Basinski and C.D. Naylor, "A survey of provider experiences and perceptions of preferential access to cardiovascular care in Ontario, Canada" (1998) 129 *Annals of Internal Medicine* 567 at 572.

and address the converse of preferential access – inferior access – a phenomenon which is arguably more widespread and at least as damaging to a health care system premised on equity.

CHAPTER THREE: PRINCIPLES OF INQUIRIES

All inquiries, whether appointed federally or provincially, share certain fundamental principles and objectives. As developed through the jurisprudence and the experience of recent inquiries, they are fairness, openness to the public, thoroughness and expedition.[83] This inquiry has been guided by these principles and objectives throughout its work.

The appointment of an inquiry is an act of the executive branch of government and the inquiry's jurisdiction is circumscribed by the terms of reference stipulated in the executive's order in council. Yet an inquiry is, and must be, independent. The executive cannot direct the inquiry about how to carry out its mandate. That is one distinct advantage of a commission of inquiry. It is independent of government and thus it can retain the confidence of the public, particularly if a part of government is the focus of the inquiry. There are other advantages. An inquiry is transparent since the public sees what it is doing; it can bring expertise to the investigation of the subject matter by retaining experts and allocating necessary resources; and, through its extraordinary investigative powers, an inquiry can compel the production of documents and witnesses that might otherwise be out of reach. The other significant advantage is that an inquiry is impartial, free from partisan political constraints or pressures.

However, an inquiry faces a significant limitation. Unlike a civil or criminal trial, it cannot make findings of liability or culpability. The *Health Quality Council of Alberta Act*[84] *(HQCA Act)* specifically prohibits me from issuing a report that contains any findings of legal responsibility or any conclusion of law. This also accords with common law elaborations of the powers of public inquiries. But this does not prevent me from finding facts and reaching conclusions, even if my findings reflect adversely upon individuals.[85] That is, after all, the primary purpose of this inquiry – to find facts and reach conclusions.

[83] See Ontario, *Report of the Walkerton Inquiry*, Part One (2002) at 472; Canada, Commission of Inquiry into Certain Allegations respecting Business and Financial Dealings between Karlheinz Schreiber and the Right Honourable Brian Mulroney, *Report: Volume 2 – Factual Inquiry* (Minister of Public Works and Government Services Canada, 2010) at 7.

[84] S. 22(3).

[85] See *Canada (Attorney General) v. Canada (Commission of Inquiry on the Blood System)*, [1997] 3 S.C.R. 440 at para. 57.

Throughout this report, I have attempted to keep in mind that a public inquiry has the potential to tarnish the reputations of those who are compelled to testify and whose names are mentioned. It is easy to get caught in the media glare and publicity that follow such proceedings. The solution lies in ensuring that the inquiry's procedures are fair. And while inquiries are not bound by the ordinary rules of evidence or procedure that apply to civil or criminal trials, each inquiry establishes rules of procedure that must be fundamentally fair to all who appear before it and whose reputations may be affected by it.

The *HQCA Act* and the *Public Inquiries Act* stipulate that if it is intended that a commissioner's report will allege misconduct by any person, or may adversely affect a person, that person shall be given reasonable notice and the opportunity to give evidence or make representations on the matter before the report is issued.[86]

No such "notices of misconduct" were issued during this inquiry. I do make findings in this report about the conduct of certain individuals, but I am satisfied that the requirements of procedural fairness, as reflected in these statutory provisions, have been met. The inquiry's rules of procedure and the process adopted by all parties protected every witness. In particular, all parties with standing and all witnesses appearing before the inquiry had the right to counsel, both at the inquiry and during pre-testimony interviews. Each party with standing and each witness affected by the testimony of another witness had the right to cross-examine that witness through their counsel. All parties and witnesses had the right to receive copies of all documents to be referred to during their testimony. Commission counsel undertook to identify specific lines of questioning or events prior to any pre-testimony interviews. Finally, Commission counsel provided written summaries based on those interviews to any witness called by Commission counsel and his or her counsel.

All of these procedures were fair and provided witnesses with ample notice of the lines of inquiry and adequate protection for their interests. I do not think any witness can complain about being taken by surprise by any of the findings in this report.

[86] *Public Inquiries Act*, R.S.A. 2000, c. P-39, s. 13; *Health Quality Council of Alberta Act*, S.A. 2011, c. H-7.2, s. 22(2).

I wish to emphasize, however, that any findings of fact and conclusions contained in this report should not and cannot be taken as findings of criminal or civil liability. Nor should they be taken as conclusions as to breaches of professional ethical or practice standards. Wherever I use such terms as “improper” or “inappropriate” or any word of a similar nature, it should be understood that I do not intend to indicate any conclusion of law by using those terms or to equate them with how they may be used in a professional discipline context. My intention is simply to give them the usual non-legal meaning that the public would ordinarily attach to them.

Finally, respecting the process I followed, it is important to recognize, as I said earlier, that this inquiry was of a type described as a mixed investigative/advisory inquiry. The terms of reference call for a fact-finding inquiry into whether improper preferential access is occurring and, if it is, a policy-focused inquiry leading to recommendations to prevent it from occurring again. Such inquiries are common, since merely investigating an event without looking at systemic or policy issues surrounding that event would not be very useful. Such an inquiry would ordinarily occur in two phases, the first being confined to witnesses and other evidence relevant to the fact-finding exercise and then, if the facts warrant it, a second phase consisting of expert evidence on policies and procedures.

It was apparent from the start of this inquiry that such a divided process would take much more time than was available under the deadline set by the initial order in council. To save time and costs, I decided to have the two phases overlap. The process must try to balance fairness and thoroughness with efficiency. This required all participants to keep in mind the distinction between evidence related to fact-finding and expert evidence relating to policies, a distinction made easier to grasp because the expert witnesses testified in the last days of the inquiry’s public hearings.

CHAPTER FOUR: THE INQUIRY PROCESS

A. *General*

This inquiry was established pursuant to section 17 of the *Health Quality Council of Alberta Act*[1] *(HQCA Act)* on February 28, 2012, when the Lieutenant Governor in Council issued Order in Council 80/2012.

That order directed the Health Quality Council of Alberta (HQCA) to appoint a panel of one or more persons to conduct the inquiry. On March 16, 2012, the HQCA board appointed me the sole commissioner for the panel for this inquiry.

Creating this inquiry under the provisions of the *HQCA Act* had certain organizational ramifications that I discuss in Appendix 1. However, the *HQCA Act* did not dictate my powers as commissioner other than to provide that the panel appointed to conduct an inquiry has all the powers, privileges and immunities of a commissioner under the *Public Inquiries Act*[2] (something repeated expressly in the order in council).

B. *Organization*

Every inquiry must handle multiple administrative tasks in its work. Staff have to be recruited, counsel retained, office premises and communication systems established, rules of procedure drafted and public hearings arranged. This work is primarily the responsibility of the inquiry's executive director.

I think it is fair to say that this inquiry encountered quite a few organizational issues, due in no small part to this being the first public inquiry conducted in Alberta in many years and the very first inquiry called under section 17 of the *HQCA Act*. There were delays in setting up the administrative apparatus due to the election called on March 26, 2012. From that date until the provincial election on April 23, 2012, very little could be done because the initial budget approval and advance of funds to finance the inquiry operations could not occur until after the election and the swearing-in of a new cabinet. In addition, financial arrangements were made more complicated by the three-party relationship contemplated by the Act and the order in council – that of

[1] S.A 2011, c. H-7.2.
[2] R.S.A. 2000, c. P-39.

the government, the HQCA and the inquiry. I discuss some of these difficulties in Appendix 1 to this report. Since this inquiry will help to serve as a template for future inquiries under section 17 of the Act, I also offer suggestions there on how future inquiries can be organized.

C. *Commission counsel*

The role of commission counsel is particularly important since counsel are responsible for ensuring that matters bearing on the mandate of the inquiry are brought forward. Commission counsel identify the issues to be investigated, supervise the investigations and witness interviews, obtain disclosure of documents, determine who will be called as witnesses and lead the evidence at hearings.

As has often been said, a commission of inquiry is not a trial. The role of commission counsel is not like that of a prosecutor in an adversarial process. Commission counsel, like a commissioner of inquiry, must be objective and impartial. The role was aptly described by Justice Dennis O'Connor in a 2003 paper:

> The role of commission counsel is quite different from that of a lawyer in most other legal proceedings.… The difference stems from the relationship between commissioner and commission counsel. That relationship is altogether different from the usual one between a judge and a lawyer. The commissioner appoints his or her counsel and it is often said, aptly I think, that a commission counsel becomes the alter ego of the commissioner.
>
> As a result, commission counsel's role is not to advance any particular point of view, but rather to investigate and lead evidence in a thorough, but also completely impartial, and balanced, manner. In this way, the commissioner will have the benefit of hearing all of the relevant facts or evidence unvarnished by the perspective of someone with an interest in a particular outcome.[3]

When making their final submissions before this inquiry, some counsel for the participants raised concerns about the approach of Commission counsel. They criticized Commission counsel for going beyond

[3] Justice Dennis O'Connor, "The Role of Commission Counsel in a Public Inquiry" (2003) 22(1) *Advocates' Soc. J.* 9-11.

summarizing the evidence and drawing conclusions and making recommendations. Some criticized Commission counsel for a lack of objectivity because of some selective choice of evidence.

These criticisms are totally unwarranted. Commission counsel, throughout this process and particularly during the hearings, exhibited those traits identified in the extract above: impartiality and fairness. The decision as to what evidence to call is precisely the responsibility of Commission counsel. If at times Commission counsel appeared to take a less-than-passive approach to a witness, it must be remembered that counsel sometimes has to be a bit more active and persistent to obtain a thorough and truthful account from a witness.

I also reject the criticism of Commission counsel for drawing conclusions and making suggestions as to recommendations. Commission counsel acts in the public interest and no one has a more comprehensive knowledge of the evidence. The final submissions of Commission counsel can therefore be highly valuable in identifying the important points in the evidence, what conclusions may or may not be drawn from them, and what recommendations may appropriately be made based on those conclusions. This is no different than the submissions of counsel for the other inquiry participants, who also showed no hesitation in urging me to come to certain conclusions and arguing for certain recommendations. This is all proper advocacy. And, as I stated at the time of the final submissions, no one should doubt that the conclusions I reach and the recommendations I make are my own.

D. *Witnesses and evidence*

The work of Commission counsel and her associates was particularly demanding. The only information counsel had at the outset came from press reports of the queue-jumping allegations and the Duckett memo of 2009 dealing with requests for preferential or expedited care.

Unlike most investigative inquiries, there was no specific event to examine, and certainly no earlier investigations to start from. Counsel began their investigation with the time period and events leading up to the Duckett memo. They also had lists of the senior employees and board members of the nine health regions that existed prior to the creation of AHS and contacted most of those people. Counsel also interviewed the current senior management people at AHS and the health ministers and deputy health ministers in place during what

counsel considered to be the relevant period. Some events counsel wanted to examine – for example, the Calgary Flames H1N1 vaccination issue – had been widely reported, so counsel began investigations with the individuals or organizations that would have relevant information. In other cases, the initial information came from people contacting the inquiry through its website or contacting Commission counsel directly.

As well, in the early days of organizing the inquiry, a website was established that provided the inquiry's contact details and invited anyone with pertinent information to contact the inquiry on a confidential basis. The inquiry received hundreds of emails, letters and website responses from members of the public. Counsel examined all of these communications.

Commission counsel, with the co-operation of counsel for the Alberta Medical Association, also posted a letter to Association members on its website. The letter sought assistance in uncovering instances of improper preferential access to publicly funded health services. Physicians were asked to contact Commission counsel if they had relevant information.

Witnesses generally came to the attention of Commission counsel in one of the following ways: (i) they responded through the inquiry website and were then contacted by Commission counsel or inquiry staff; (ii) they were presented or suggested to counsel by interveners or interveners' counsel; or (iii) individuals became known to Commission counsel during investigations, including reviews of media reports, website information, document production and analysis, or during interviews of other witnesses.

Commission counsel developed an agreed-upon pre-hearing witness interview protocol with intervener counsel. The interviews were not recorded by audio or video, but Commission counsel took notes. Following the interview, Commission counsel would create an interview summary and circulate that to counsel for the witness. The witness could correct inaccuracies in the summary so that his or her evidence before the inquiry could largely accord with the summary. Once the form of the interview summary was agreed between Commission counsel and counsel for the witness, it was then circulated to other intervener counsel and counsel for any other parties who might have an interest in that anticipated testimony, along with any

documents referred to in the summary or later identified as being relevant to the testimony of that witness.

Almost all interviews were conducted in person, although some had to be done by telephone because of distance or shortage of time. The interviews were almost always conducted with other counsel present. Because most witnesses were current or former members of either AHS or the Government, it was usually counsel for those interveners who were present. However, some witnesses obtained their own counsel and many witnesses came directly to Commission counsel and did not want separate counsel for their interviews.

Further, where a person was simply providing Commission counsel with second-hand information about an event or another person who might be involved in queue-jumping, counsel investigated that information to identify the primary actors and attempted to elicit first-hand evidence at the hearings.

E. *Limits and proportionality*

One difficulty confronting Commission counsel lay in establishing reasonable limits on gathering evidence. Counsel could go on and on uncovering instances where some conduct could be said to constitute improper preferential access. But the principle of proportionality must come into play at some point. Decisions have to be made about the relative importance of any piece of evidence. As well, counsel had to decide when enough evidence was heard to allow meaningful conclusions. We did not, and should not, have the luxury of carrying on our work indefinitely in some expectation that more evidence would necessarily be better evidence. Evidence needed to be presented in a manner proportionate to its significance to our mandate. Participants in this process had to be mindful of the cost and the time expended.

F. *Budget*

The order in council establishing this inquiry required me to prepare a budget and submit it to the Lieutenant Governor in Council through the Minister of Health for review and approval. It also required me to put a system of budget monitoring and reporting in place, such reporting to be to the Minister of Health. I comment about some of the implications of this last requirement in Appendix 1 to this report.

My executive director worked extensively with HQCA personnel to prepare the budget. Many standard budget items are common to all commissions of inquiry, such as fees for legal counsel, administration and personnel costs, office and equipment, hearing facility costs and report production. This was a difficult process considering we had little knowledge when the budget was being prepared as to how extensive our work would need to be or how many hearing days would be required.

Order in Council 264/2012 approved the budget on July 25, 2012, allocating $8,258,000, with an additional $1,742,000 as a contingency fund. The order in council also called for the HQCA to administer the funds.

The funding conditions required a grant agreement between the provincial government and the HQCA. That in turn required the implementation of a second agreement between me (as the panel for the inquiry) and the HQCA. These agreements were not finalized until mid-September 2012, delaying the advance of funds until then. This caused significant delays in the inquiry's work (notwithstanding the interim administrative and financial support – eventually repaid from the inquiry budget – provided by the HQCA).

I am pleased to report that this inquiry carried out its mandate within its budget, without requiring contingency funds, and with a surplus to be sent to the provincial treasury.

G. *Standing and funding*

The inquiry's initial order in council also required me to develop and submit a policy to the Lieutenant Governor in Council on whether assistance would be provided to witnesses or interveners to prepare submissions or for the costs of legal counsel. To develop a policy on funding, a policy on grants of standing was necessary first. One goes with the other since standing as an intervener, or being called as a witness, are prerequisites to an application for financial assistance.

Canadian jurisprudence about commissions of inquiry recognizes the importance of allowing interventions by parties who have a direct and substantial interest in the proceedings. This helps ensure that an inquiry is able to fulfill its mandate by having before it all the relevant facts and circumstances. It also ensures fairness, both procedurally and

substantively. The jurisprudence also recognizes that funding may be necessary for those parties who show an inability to participate meaningfully without financial assistance. This also helps ensure fairness.

With respect to grants of standing as an intervener, the policy I implemented required applicants to satisfy me that:

a) the applicant was or might be directly or substantially affected by the inquiry; or

b) the applicant had or represented a clearly ascertainable interest or perspective, which ought to be separately represented at the inquiry, and which would assist the inquiry to fulfill its mandate.

My policy on funding set out that an intervener, or a witness called to testify before the inquiry, might apply for funding by submitting:

a) a sworn statutory declaration proving that the applicant did not have sufficient financial resources from any source to enable it to meaningfully participate in the inquiry;

b) a written budget outlining the applicant's proposed involvement in the inquiry and the estimated costs to be incurred by the applicant; and

c) a written proposal as to how the applicant would account for funds received.

The criteria by which I was to consider each application, as outlined in the policy, were as follows:

a) whether the applicant was a witness, intervener or both;

b) in the case of applicants who were witnesses, whether the applicant's testimony was being compelled by Commission counsel;

c) the nature and extent of the applicant's interest, including whether the applicant might be adversely affected by the inquiry report;

d) whether the applicant had a demonstrated record of concern for and commitment to the interest it sought to represent;

e) whether the applicant had special experience or expertise relevant to the inquiry's mandate; and

f) whether the applicant could reasonably be included in a group with others of similar or overlapping interests.

The policy also stipulated that, after consideration and approval of an application for funding, I would make a recommendation about funding to the Lieutenant Governor in Council. This procedure followed well-established precedents from inquiries in other Canadian jurisdictions. In this manner, the government retained ultimate control over the expenditure of public funds.

My funding policy for witnesses and interveners was approved by Order in Council 264/2012 on July 25, 2012.

On October 17 and 18, 2012, I heard applications for standing and funding. I issued rulings on October 19, 2012. I granted standing, with full intervener rights, to four organizations: Alberta Health Services, the Government of Alberta as represented by the Ministry of Health, the Alberta Medical Association and the Consumers' Association of Alberta. The first three play significant roles in delivering publicly funded health services in Alberta. I concluded that the fourth, the Consumers' Association, could bring a valuable public perspective to the inquiry's work, a perspective different from that of health providers, government and professional organizations.

"Full intervener rights" means that each intervener had participation rights as follows:

a) the right to be present and represented by counsel throughout the inquiry;

b) the right to make submissions;

c) the right to receive advance disclosure of evidence to be called, and documents to be referred to, by Commission counsel in accordance with the inquiry's rules of procedure;

d) the right to suggest to Commission counsel the names of witnesses who should be called or evidence that should be presented and, in the event of a dispute, the right to apply to me for directions; and

e) the right to cross-examine witnesses.

I recommended funding of up to $120,000 for the Consumers' Association of Alberta to assist with its representations. (On March 15, 2013, I recommended additional funding of $28,000). I also recommended funding of $5,000 for the Renal Dialysis Rimbey Support Group, a community-based, non-profit organization from Rimbey, Alberta, to obtain expert assistance in preparing a submission to the inquiry.

I subsequently communicated my recommendations on funding to the Minister of Health and on October 29, 2012, the Lieutenant Governor in Council issued Order in Council 383/2012 approving the funding.

H. *Rules of procedure*

Commission counsel examined numerous precedents for procedural rules from other commissions of inquiry and prepared a draft for my consideration. Counsel also consulted interveners' counsel for comments on the draft rules. Commission counsel also created forms entitled Notice to Disclose Records and Notice to Attend, reflecting my powers under the *Public Inquiries Act* and the *HQCA Act*.

The Rules of Practice and Procedure I ultimately adopted were meant to ensure fairness and efficiency in inquiry proceedings. A copy of those rules was posted on the inquiry website with all other policy documents and rulings. (Copies are reproduced in Appendix 4 to this report).

I. *Privacy and confidentiality issues*

Any inquiry involving health matters raises significant concerns about privacy and confidentiality, particularly of patient health records. Alberta has strong mechanisms in the *Health Information Act*[4] and the *Freedom of Information and Protection of Privacy Act*[5] to protect the privacy of individuals with respect to their health information and to preserve the confidentiality of that information. This presented challenges to the inquiry in compelling production of documents containing personal health information.

[4] R.S.A. 2000, c. H-5.
[5] R.S.A. 2000, c. F-25.

Early in our proceedings, Commission counsel retained Mr. Sean Ward of the firm of Reynolds Mirth Richards & Farmer of Edmonton to provide an opinion on these privacy issues. I was satisfied, after receiving that opinion, that the powers granted to me as the commissioner of inquiry pursuant to both the *Public Inquiries Act*[6] and the *HQCA Act*[7] were sufficient to overcome, if necessary, the restrictions imposed by these two privacy statutes. Even so, Commission counsel was careful to preserve confidentiality of personal health information during these proceedings.

The Rules of Practice and Procedure used by the Inquiry provided that all documents provided to Commission counsel would remain confidential unless and until made exhibits in the course of the inquiry. The exception was Commission counsel's obligation to provide documents to any participants whose interests the documents might affect. Interveners and participants who received advance copies of documents in this way signed undertakings acknowledging their obligations of non-disclosure.

For witness interviews, Commission counsel did not provide assurances of confidentiality (other than those relating to personal health information) or grant anyone immunity from testifying. Because of the nature of a public inquiry, Commission counsel felt that she had to retain the ability to call evidence from any witness whose testimony was relevant to the questions before the inquiry. However, counsel did not generally disclose the identity of interviewees or the information they possessed unless calling them as witnesses.

J. *Research and expert witnesses*

Under the guidance of the inquiry's director of research, Mr. John McGurran, a group of 13 experts was consulted for preliminary views on the concepts raised by the issue of improper preferential access. This group included clinicians, medical ethicists, academics and health administrators. Six individuals from this larger group were asked to elaborate on their opinions and testify. Those were:

[6] In particular, s. 9.
[7] In particular, s. 17(7).

- Dr. H. Brian Goldman, MD
 - Staff emergency physician, Mount Sinai Hospital, Toronto
 - Assistant Professor, Department of Family and Community Medicine, University of Toronto
 - Host, *White Coat, Black Art*, a CBC Radio One show about the culture of modern medicine

- Lynette Reid, PhD
 - Associate Professor, Department of Bioethics, Faculty of Medicine, Dalhousie University
 - Member, Division of Medical Education, Dalhousie University
 - Member, Faculty of Graduate Studies, Dalhousie University

- Pam Whitnack, MBA
 - President, Whitnack and Associates Ltd.
 - Executive Vice-President, Rural, Public and Community Health, Alberta Health Services, 2008-11
 - Chief Executive Officer, Chinook Health Region, 2005-08

- Dr. David A. Alter, MD, PhD, FRCPC
 - Cardiologist, Toronto Rehabilitation Institute – University Hospital Network
 - Associate Professor, Department of Medicine, University of Toronto
 - Senior Scientist, Institute for Clinical Evaluative Sciences

- John Church, PhD
 - Associate Professor, Department of Political Science and Centre for Health Promotion Studies, University of Alberta
 - Principal, JC Paragon Consulting Services Ltd.
- Dr. Owen Robert Heisler, MD, MSc, MBA, FRCSC, FACS, FCCHL, FACPE
 - Assistant Registrar, College of Physicians & Surgeons of Alberta
 - General Surgeon, Red Deer, Alberta 1988-2008
 - Assistant Clinical Professor, University of Alberta
 - Site Medical Director Red Deer Regional Hospital, December 2004 - March 2006

Two additional experts testified at the start of our hearings. Prof. William Lahey, associate professor at the Schulich School of Law and former director of the Health Law Institute at Dalhousie University, presented a report explaining the *Canada Health Act* and the legislative framework governing access to publicly funded health services in Alberta. Mr. James L. Saunders, a consultant with over 30 years' experience in the Alberta health care system, presented a report on the delivery of health care in Alberta and the organizational relationship between government and service providers.

Mr. McGurran also arranged for an academic literature review of preferential access to health care in Canada. The review was authored by Dr. Nishan Sharma of the Faculty of Medicine at the University of Calgary. Dr. Sharma and his associate, Ms. Garielle Brown of W21C, a research team at the University of Calgary, later prepared a compilation and categorization of the expert oral and written testimony provided to the inquiry.

K. *Public hearings*

Public hearings were held in Edmonton (December 4 to 13, 2012) and Calgary (January 7 to 18 and February 19 to 27, 2013), with final submissions heard in Edmonton (April 3 and 4, 2013). The hearings were open to the public and the press. Closed-circuit television links

were provided to a separate media room so reporters could work as the hearings progressed.

Real-time reporting was provided at the hearings, with transcripts prepared overnight. Transcripts of each day's testimony and copies of all exhibits entered into the record were promptly posted on the inquiry website.

Arrangements were made for live webcasts of the hearings over the inquiry website. There were over 3,770 webcast views during the public hearings. Viewers from Canada predominated, but there were also viewers from the United States, Europe, Australia and Asia.

L. *Delivery of the report*

Order in Council 80/2012 directed me to submit a report of my findings and recommendations to the Speaker of the Legislative Assembly by April 30, 2013. That deadline was subsequently extended, at my request, to August 31, 2013 by Order in Council 40/2013. The primary reason for the extension request was the need to schedule more hearing dates than originally anticipated, which in turn delayed the making of final submissions. It became apparent that meeting the original deadline was not feasible given the time required to review the evidence and draft, print and publish the report.

Section 22 of the *HQCA Act* speaks specifically to the delivery of the report in subsections (5), (6), (7) and (8):

> 5) On completion of the report, the Panel shall submit the report to the Speaker of the Legislative Assembly.
>
> 6) On receiving a report under subsection (5), the Speaker of the Legislative Assembly shall lay the report before the Legislative Assembly if it is then sitting or, if it is not then sitting, within 15 days after the commencement of the next sitting.
>
> 7) The Legislative Assembly may refer a report tabled under subsection (6) to a special committee of the Legislative Assembly to review the report and make recommendations to the Assembly.

8) If the Legislative Assembly is not sitting when the report is submitted to the Speaker, the Speaker shall make copies of the report available to the public.

The recommendations in this report are of course just that – recommendations. My hope is that the legislature will consider them carefully, touching as they do on one of Alberta's most important assets, its publicly funded health care system.

SECTION II: CONCEPTS, DEFINITIONS, AND SYSTEMS

CHAPTER ONE: HEALTH CARE SERVICES IN ALBERTA: LAWS AND STRUCTURES

Obtaining a complete sense of how the health care system in Alberta operates is almost an impossible task. The provincial health care system is enormously complex and involves service to millions of Albertans through a multitude of mechanisms. It is regulated by a range of federal and provincial legislation and professional codes.

The final submissions of the Government of Alberta described the vehicles for providing health care services in Alberta. These serve to highlight the complexities involved in delivering health care in the province:

> Publicly funded health services are provided through a wide range of institutional and community settings across Alberta. Those settings include Hospitals (including emergency departments, cancer clinics and other types of clinics), urgent care centres, public health centres, ambulatory care centres, primary care networks, family care clinics, physicians' offices, supportive living facilities, long-term care facilities (such as nursing homes and auxiliary hospitals), non-hospital surgical facilities ("NHSFs"), diagnostic imaging clinics, labs, pharmacies, correctional centres and other specific types of clinics established to address particular health conditions.[1]

While it may be next to impossible to understand every aspect of the health care system, this inquiry needed a basic explanation of the system's legislative and organizational framework. To this end, Commission counsel engaged two experts identified earlier. The first was Prof. William Lahey, who examined the legislative framework governing access to health services that are "insured health services" under the *Canada Health Act*[2] and "insured services" under Alberta legislation.[3] The second was Mr. James L. Saunders, who prepared a

[1] Closing Submissions of the Government of Alberta, March 28, 2013, at 7 (Exhibit 168).
[2] R.S.C. 1985, c. C-6.
[3] William Lahey, *The Legislative Framework Governing Access to Health Services that are "Insured Health Services" under the* Canada Health Act *and "Insured Services"*

study on how health care is delivered in Alberta.[4] In essence, he described the organizational relationship between government and service providers, explaining the basics of what health care is available to Albertans and through which channels. Both Prof. Lahey and Mr. Saunders elaborated on their written reports in oral testimony before the inquiry in December 2012.

The inquiry also benefitted from submissions by various interveners, including the closing submissions of the Government of Alberta, which described the interaction between various pieces of provincial and federal legislation and also summarized the governance structure for publicly funded health care in Alberta. The 2002 report of the Hon. Roy Romanow, *Building on Values: The Future of Health Care in Canada: Final Report*, also helped to paint a broad picture of the legislative background and structural framework of Canada's publicly funded health care system as a whole.

This chapter merely seeks to give readers a brief overview of the legislation and governance structures relating to publicly funded health care in Alberta. The goal is to help understand the context in which issues relating to preferential access arise. If readers need a more complete understanding of the legislation behind the organization of health care in Alberta and in Canada as a whole, they can refer to the sources cited above.

This section relies heavily on the research of Prof. Lahey and Mr. Saunders. I have not inserted detailed references to their work, but it can be understood that much of the following text is based on their research.

A. *The legislative framework*

(i) The *Canada Health Act*

Health care in Canada is a shared provincial-federal responsibility. Federal legislation, the *Canada Health Act*, entitles Alberta to its share of cash transfers that the federal government makes each year to the provinces and territories for expenses they incur in funding health care.

under the Legislation of Alberta: A Report to the Health Services Preferential Access Inquiry of the Province of Alberta, November 30, 2012 [Exhibit 11] [Lahey Report].

[4] J.L. Saunders & Associates Inc., *How Health Care is Delivered in Alberta*, November 29, 2012 [Exhibit 12] [Saunders Report].

The *Canada Health Act* is primarily a funding mechanism. Section 4 of the Act makes this clear:

> The purpose of this Act is to establish criteria and conditions in respect of insured health services and extended health care services provided under provincial law that must be met before a full cash contribution may be made.

This funding mechanism means paying 100 per cent of the cost of what the Act defines as insured health services. It defines these in part as "hospital services, physician services and surgical-dental services provided to insured persons…." Essentially, this means those services that are medically necessary or medically required. To obtain that 100-per-cent funding, the health care insurance plan in Alberta must satisfy the following five criteria set out in the *Canada Health Act*:

1) public administration;
2) comprehensiveness;
3) universality;
4) portability; and
5) accessibility.

The Romanow report notes that the principles of the *Canada Health* Act – which are known as the Five Criteria – began as simple conditions attached to federal funding for medicare. "Today," the report continues, "they represent both the values underlying the health care system and the conditions that governments attach to funding a national system of health care."[5]

In addition, for the health services that the provincial health plans insure, the *Canada Health Act* prohibits extra-billing and user charges. There are some exceptions to the obligation to comply with the Five Criteria. Some groups receive access to health care through other means and the Act therefore does not include them in the definition of "insured persons." These are members of the Canadian Forces, inmates in federal penitentiaries and, until recently, members of the RCMP. As well, the "insured health services" covered by the Act do not include

[5] Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada: Final Report* (Ottawa, 2002) at 60.

services relating to workers' compensation that are available under provincial or other federal legislation.

The annual transfer provides a significant financial incentive to the provinces to comply with the *Canada Health Act*. Prof. Lahey cites estimates that provincial and territorial government health expenditures would reach $135 billion in 2012 and notes that spending on health care is one of the largest budget items for all provinces.

In short, medicare seeks to ensure access to necessary physician and hospital services (as well as some dental services) regardless of each individual's wealth. In this sense, medicare seeks to ensure equality of access generally to the health services it encompasses.

(ii) Alberta health legislation

Alberta residents are generally entitled to the categories of health service identified in the *Canada Health Act* without being charged for the service:

1) medically required services provided by a physician;
2) medically necessary services provided by a hospital; and
3) surgical-dental services that are medically or dentally required if performed in a hospital where the service is one that must be provided in a hospital.[6]

The *Canada Health Act* requires provinces and territories to have a publicly administered health care insurance plan. The Alberta version of the health care insurance plan that the Act requires in fact consists of two plans, one established under the *Alberta Health Care Insurance Act*[7] and the other under the Alberta *Hospitals Act*.[8]

Under the *Alberta Health Care Insurance Act*, the payment of benefits for insured services depends on the physician or dentist who provides the service being "opted in" to the health insurance plan.[9] No physician or dentist and no resident may receive the payment of benefits under

[6] *Canada Health Act*, R.S.C. 1985, c. C-6, s. 2.
[7] R.S.A. 2000, c. A-20.
[8] R.S.A. 2000, c. H-12.
[9] R.S.A. 2000, c. A-20, s. 6(1).

the plan in respect of insured services unless the physician or dentist had opted in to the plan when the services were provided.[10] The prohibition on extra billing only applies to physicians or dentists who have opted in to the plan.

Opting out allows doctors and dentists in Alberta to make services that are available to all Albertans through medicare available on different and possibly preferential terms to Albertans who are able and prepared to pay for those services. Still, opting out is a rarity in Alberta. The 2010-11 annual report of Health Canada on the *Canada Health Act* says that "as of March 31, 2011, there were zero opted out physicians in [Alberta]."[11]

In addition, the Alberta *Health Care Protection Act*[12] deals with the funding and delivery of insured and uninsured surgical services and with the role of private surgical facilities in the provision of those services.

B. *Structure and governance of health care in Alberta*

In Alberta, publicly funded health services are delivered by the following providers:

1) Health care practitioners who bill fee-for-service for the health services provided (for example, physicians);

2) Alberta Health Services (AHS) through the health care practitioners it employs directly in its facilities (for example, nurses);

3) Health care practitioners who are employed or under contract with AHS to provide health services (for example, the Chief Medical Officer of Health);

4) Health care practitioners who contract with AHS to provide health services (for example, physicians in non-hospital surgical facilities); and

[10] R.S.A. 2000, c. A-20, ss. 6(1) and (2).
[11] Health Canada, *Canada Health Act – Annual Report 2010-2011* (Ottawa: Health Canada, 2011) at 96.
[12] R.S.A. 2000, c. H-1.

5) Health care practitioners who operate under Government of Alberta programs (for example, physicians under Alternative Relationship Plans).[13]

The Minister of Health, Alberta Health and AHS have roles in the Alberta health care system. Alberta Health sets strategic direction for the health system through the following:

- Legislation, policy and standards;
- Allocation of public funding; and
- Administration of provincial programs.[14]

The Government of Alberta sets funding levels. In recent decades it has also overseen a major restructuring of health boards in the province.

In May 1994 there were 193 health care boards in Alberta: 128 acute care hospital boards, 25 public health boards and 40 long-term care boards. In June 1994, under the authority of the *Regional Health Authorities Act*,[15] the Minister announced a reduction in the number of health care boards from 193 to 17 new health region boards. In addition, the Alberta Cancer Board and the Alberta Mental Health Board would remain in place, with province-wide responsibilities. The goal of the change was to increase the efficiency of the health system.[16]

In April 2003 the number of health regions was reduced from 17 to 9. The Alberta Cancer Board and the Alberta Mental Health Board remained in place. This change enabled the boundaries of the large and medium-sized health regions to expand to include smaller rural health regions whose populations were already accessing and depending on health services from the larger regions. The 2003 changes were based on the assumption that fewer health regions with more resources, larger budgets and responsibility for managing health services for larger catchment areas and service populations would achieve efficiencies within the system. The greater scope was expected to streamline government interaction with the health system and improve the

[13] Closing Submissions of the Government of Alberta, March 28, 2013, at 7 (Exhibit 168).
[14] Closing Submissions of the Government of Alberta, March 28, 2013, at 6 (Exhibit 168).
[15] R.S.A. 2000, c. R-10.
[16] Government of Alberta, News Release and Backgrounder, One Provincial Board to Govern Alberta's Health System, May 15, 2008.

management of the health regions, quality of care, standardization of policies and procedures and coordination of services.

In May 2008 the Minister announced that Alberta would be moving to one provincial governance board to coordinate the delivery of health services across Alberta. This would be done through AHS. Now the regional health authority, AHS is responsible for overseeing the planning and delivery of health supports and services in the province.

The goal of this restructuring was, as the minister of the time stated, "to improve the way health care is administered in this province…."[17] A background document released at the time stated that the new governance model was intended to strengthen a provincial approach to managing health care services, including surgical access, long-term care, chronic disease management, addictions and mental health services as well as health workforce and access to primary care.[18]

Under section 8 of the *Regional Health Authorities Act*, the Minister may give directions to AHS for the purpose of (a) providing priorities and guidelines for it to follow in the exercise of its powers, and (b) coordinating the work of the regional health authority with the programs, policies and work of the government and public and private institutions in the provision of health services in order to achieve the best health outcome and to avoid duplication of effort and expense. AHS reports to the Minister through its board. The Minister appoints each member of the AHS board, and board members hold office for a specified term or until removed earlier, at the discretion of the Minister.

Section 5 of the *Regional Health Authorities Act* sets out the obligations of AHS:

- promote and protect the health of the population in the health region and work toward the prevention of disease and injury;
- assess on an ongoing basis the health needs of the health region;
- determine priorities in the provision of health services in the health region and allocate resources accordingly;

[17] Government of Alberta, News Release and Backgrounder, One Provincial Board to Govern Alberta's Health System, May 15, 2008.
[18] Government of Alberta, News Release and Backgrounder, One Provincial Board to Govern Alberta's Health System, May 15, 2008.

- ensure that reasonable access to quality health services is provided in and through the health region; and
- promote the provision of health services in a manner that is responsive to the needs of individuals and communities and supports the integration of services and facilities in the health region.

These changes to the organization of the health care system in 1994, 2003 and 2008, had serious repercussions for the people working in the system. In its 2012 report, the Health Quality Council of Alberta noted that the magnitude and frequency of the organizational changes created a sense of "chaos and instability."[19] That report recommended that the government and AHS undertake no further restructuring without first having a clear rationale for the change and an effective process of consultation with stakeholders and the public.[20]

One further change in the governance of the Alberta health system in 2008 was the creation of a contractual relationship between Covenant Health and AHS. Covenant Health (formerly Caritas Health) is an Alberta-based Roman Catholic organization that provides acute care, continuing care, assisted living, hospice, rehabilitation, respite care and seniors housing in 12 communities across Alberta. Covenant Health operates about 950 acute care beds and about 1,350 continuing care beds in the province. Before 2008, Covenant Health had a working relationship with the (former) Capital Health Region. In 2008, it was agreed that Covenant Health would continue to operate with its own board but that it would sign a formal cooperation and services agreement with AHS.[21] As a result, AHS maintains the overall accountability for the health care system.

Covenant Health is a contractor that, according to Mr. Saunders, works "in harmony" with AHS to ensure that the services provided by Covenant Health meet the expectations of AHS.[22]

[19] Health Quality Council of Alberta, *Review of the Quality of Care and Safety of Patients Requiring Access to Emergency Department Care and Cancer Surgery and the Role and Process of Physician Advocacy* (February 2012) at 185.
[20] Health Quality Council of Alberta, *Review of the Quality of Care and Safety of Patients Requiring Access to Emergency Department Care and Cancer Surgery and the Role and Process of Physician Advocacy* (February 2012) at 186.
[21] AHS Board Meeting Minutes, December 2, 2010, at 7-8.
[22] Testimony of James Saunders, Transcripts, vol. 2, December 3, 2012, at 96-97.

CHAPTER TWO: DEFINING ACCESS: PREFERENTIAL, PROPER AND IMPROPER

A. *General*

A recurring theme throughout this inquiry has been the lack of an accepted definition of improper preferential access. The Canadian health care system is designed to ensure that residents have reasonable access to medically necessary physician and hospital services. That "reasonable access," however, can be facilitated or inhibited in any number of different ways – by policy decisions on the allocation of resources, by geography or socio-economic factors, and by discretionary decision-making on the part of health care providers and administrators, to name a few. The focus of this inquiry is actions that lead to preferential access that is improper within the context of the Canadian health care system. Hence there is a need to define preferential access and what is improper.

In essence, preferential access implies an advantage, a priority, over that which would be regarded as normal access, access that meets accepted clinical and organizational norms. What is reasonable is very much a contextual concept, dependent on the circumstances of the particular situation. Conferring a preference, however, assumes that one is making a choice to benefit one individual over others who are similarly situated. The issue is whether that preference can be justified on medical or ethical grounds or on the basis of some broad social principle. And if it cannot be justified, then it likely cannot be proper or reasonable.

There are a number of examples of attempts to define improper preferential access and queue-jumping. These terms have been used interchangeably but they are not necessarily the same. Getting a better hip implant than others might be considered preferential access, or at least preferential treatment, but it need not involve getting faster service. An article from 2007 defined queue-jumping as "the favourable placement or prioritization of a patient in a waiting list for reasons other than medical need."[1] One expert who appeared before the inquiry, Dr. Brian Goldman, described the common elements of the definition in the medical literature to include "preferred access to and

[1] Steven Marc Friedman, Lee Schofield & Sam Turkos, "Do as I say, not as I do: a survey of public impressions of queue-jumping and preferential access" (2007) 14 *Eur. J. of Emergency Medicine* 260 at 260.

utilization of medical services for different patients of equivalent medical need based on factors other than medical need."[2] Another expert witness, Dr. Lynette Reid, defined improper preferential access as "*differential access* to any of a comprehensive set of medically necessary health care services, where that differential access is *based on medically and/or ethically inappropriate criteria*."[3] All of these are helpful but perhaps not necessarily complete.

I previously noted how little research has been done on the subject matter of this inquiry. This is in part due to lack of data. What little has been done demonstrates some interesting attitudes toward improper preferential access or queue-jumping by both the public and physicians.

A survey conducted in 2005 of randomly selected households in Toronto revealed ambivalence on the subject.[4] Of the people surveyed, 95 per cent expressed a commitment to the principle of equal access to health care based on need. But about half also said they would consider contacting a colleague to improve their position in a queue. Some 16 per cent reported that they did use connections in the past to improve their position on a wait list. As the authors of the survey article note, such inconsistencies between stated beliefs and actual practice simply reflect human nature when confronted by illness. However, there may also be signs of increasing strain on the health care system.[5] As wait lists for medical services grow, it is not unlikely that even those who support principles of equity and fairness will increasingly attempt to gain improper preferential access when under stress.

A survey of cardiac surgeons and hospital chief executives in Ontario in 1997 reported that 80 per cent of physicians and 53 per cent of chief executives said that they had been personally involved in managing a patient who had received preferential access on the basis of factors

[2] Exhibit 149, Expert Reports, report of Dr. Brian Goldman (February 7, 2013) at 1.
[3] Exhibit 149, Expert Reports, report of Dr. Lynette Reid (February 15, 2013) at 4 [emphasis in original].
[4] Steven Marc Friedman, Lee Schofield & Sam Turkos, "Do as I say, not as I do: a survey of public impressions of queue-jumping and preferential access" (2007) 14 *Eur. J. of Emergency Medicine* 260.
[5] Steven Marc Friedman, Lee Schofield & Sam Turkos, "Do as I say, not as I do: a survey of public impressions of queue-jumping and preferential access" (2007) 14 *Eur. J. of Emergency Medicine* 260 at 262.

other than medical need.[6] The most likely factors leading to preferential access were identified as personal ties to the treating physician or the fact that the patient was a high-profile public personality such as a politician or a hospital board member or significant donor. The survey respondents also noted that preferential access was more likely to be provided if the patients or their families were particularly well-informed about the procedure, or were aggressive and perceived as potentially litigious, or where there was pressure from the referring physician. There is no reason to think that these results are not generalizable across Canada or still pertinent, notwithstanding that the survey was conducted 15 years ago.

The reference above to the factor of a well-informed patient was highlighted by the experts who testified at the inquiry. For some, the fact that Canadians possess varying degrees of health literacy and abilities to advocate for themselves creates preferential access. Dr. Goldman said, "If somebody happens to be more educated and they know their options and they're more likely to ask about options. Absent a central triage system that would field these requests in an equitable way … then they're probably more likely to get them because they know they exist."[7] Dr. David Alter, another expert witness, said, "The biggest driver of health care utilization and getting to the queue is health-seeking behaviours of individuals…. People behaviours will vary."[8]

A news article in 2007 published the revelation by the then-president of the Canadian Medical Association, Dr. Brian Day, that he had used his status to help a family member jump the wait list for a CT scan. He also admitted using his personal friendship with a surgeon to bypass the wait list when he needed knee surgery. Dr. Day used the story to highlight his concerns about long wait times. He was quoted as saying that it was not realistic to expect people not to use their connections to jump the queue when their own or their family's health is at stake.[9]

[6] David A. Alter, Antoni S.H. Basinski, and C. David Naylor, "A Survey of Provider experiences and Perceptions of Preferential Access to Cardiovascular Care in Ontario, Canada" (1998) 129 *Annals of Internal Medicine* 567.
[7] Testimony of Brian Goldman, Transcripts, vol. 37, February 26, 2013, at 3178-79.
[8] Testimony of David Alter, Transcripts, vol. 39, February 27, 2013, at 3369.
[9] K. Jaimet, Top doctor admits to queue-jump, *CanWest News Service*, December 3, 2007.

The news story about Dr. Day simply illustrates what I said before about the continuing applicability of the survey results reported previously. Also, the fact that something may be done regularly or may be accepted as a given does not necessarily mean it is either proper or improper.

In this chapter, I want to explore some different types of preferential access, proper and improper, as well as discuss some concepts, such as physician advocacy and professional courtesy, that are well known to health care professionals but less well understood by the general public.

I also want to emphasize what I am not examining. I exclude from this discussion the everyday clinical decision-making that physicians (as well as others such as nurses) do on a regular basis. I recognize that health care professionals are required to exercise their professional judgment in a multitude of ways. No two patients are the same, even though they may be categorized the same on an acuity scale. There will always be a need for the exercise of professional judgment and, when that occurs in a responsible and credible manner, no one should label it as improper.

Witnesses cited numerous examples where considerations may come into play besides medical need. For example, in deciding when to schedule a patient, a physician might have to consider the social circumstances of the patient. Is the patient responsible for the care of others? Is support readily available for the patient after treatment? These are factors affecting patient individuality since they recognize how treatment may affect their lives.[10] Another example involves an ER doctor giving priority assessment to a highly agitated patient to avoid disrupting the smooth flow of work in an emergency room.[11]

Another example would be practical decisions prompted by the need to make full use of available resources. If a scheduled operation is cancelled at the last minute, it would be senseless to waste the time set aside for it. The operating room is available and staff have been assigned. Slotting someone else into that now open space may depend more on the ready availability of the new patient as opposed to that patient's acuity relative to others on the wait list.[12]

[10] Exhibit 149, Expert Reports, report of Dr. Owen Heisler (January 2013) at 3.
[11] Exhibit 149, Expert Reports, report of Dr. Brian Goldman (February 7, 2013) at 2.
[12] Exhibit 149, Expert Reports, report of Dr. Owen Heisler (January 2013) at 7-8.

The witnesses offered other examples, but the point is that factors are taken into account in the proper exercise of clinical judgment that simply cannot be quantified or effectively regulated. The system needs some flexibility to function well. Dr. Alter put it as follows:

> In reality, no queue is organized as a lineup – there are always circumstances, some of which are resource-based, while others [are] administrative or personal, which will result in some patients being serviced ahead of others, even where clinical severity can be measured, and be deemed objectively comparable.[13]

This is not to say that standardized criteria would not be beneficial; it merely recognizes that no two patients are alike in all circumstances and that multiple factors come into play when assessing the needs of a given patient.

So I am not concerned about the physicians' role in determining medical necessity using their professional judgment. I do not therefore consider the prioritization of patients according to medical need as an example of preferential access, proper as it may be. That is the very essence of what I call normal access.

What I am concerned about is preferential access on the basis of non-clinical criteria, whether it be by design, or by common acceptance, or by corruption of the system.

B. *Medical necessity as the foundation for a definition*

It is always helpful to go back to first principles in the search for any definition.

One of the Five Criteria of the *Canada Health Act* is accessibility. This requires provinces and territories to provide insured health services (i) on uniform terms and conditions, and (ii) on a basis that does not impede or preclude reasonable access to those services.[14] The term "reasonable access" is not defined. But other aspects of applicable legislation can assist in this regard.

[13] Exhibit 149, Expert Reports, report of Dr. David Alter (February 7, 2013) at 3.
[14] *Canada Health Act*, R.S.C. 1985, c. C-6, s. 12(1)(a).

Another of the Five Criteria in the *Canada Health Act* is comprehensiveness. This requires provinces and territories to insure all "insured health services." Those include (i) hospital services (defined in part as services that are medically necessary), and (ii) physician services (defined in part as services that are medically required).[15] Similarly, the *Alberta Health Care Insurance Act* defines insured services to include all services provided by physicians that are medically required.[16] The *Health Care Protection Act* defines facility services as any one of a list of services that are medically necessary.[17]

Taking into account all these sources, it seems that the defining criterion for reasonable access is medical necessity. This was a point made by Prof. Lahey in his research paper:

> Given … that medical necessity is the basis on which a service becomes a service that must be insured, it would seem that the reasonableness of access to those services would also depend on what is medically necessary.[18]

So the place to start is by saying that proper access is access governed by medical necessity. Preferential access is therefore a type of access that, for the patient, is advantageous to that governed by medical necessity. Whether such preferential access is proper or improper requires an examination of areas of the health care system where preferences already exist and those areas governed by attitudes and practices of the professionals in the health care system.

C. *The issue of corruption*

This inquiry was prompted by allegations of corruption. Drs. Duckett and Sherman alleged that political insiders were able to obtain preferential access for themselves and their friends. This type of behaviour would be an abuse of power; it would be the seeking of self-advantage over the rules and regulations governing health care; it would therefore be corruption, although not necessarily corruption in a criminal sense. The preamble to this inquiry's terms of reference

[15] *Canada Health Act*, s. 2.
[16] R.S.A. 2000, c. A-20, s. 1(n).
[17] R.S.A. 2000, c. H-1, s. 29(g).
[18] William Lahey, *The Legislative Framework Governing Access to Health Services that are "Insured Health Services" under the* Canada Health Act *and "Insured Services" under the Legislation of Alberta: A Report to the Health Services Preferential Access Inquiry of the Province of Alberta,* November 30, 2012, at 19 [Exhibit 11].

contains the statement that "it is improper to gain access to publicly-funded health services through threat, influence or favour." These are also corrupt acts. I do not need to engage in a detailed analysis to conclude that enhanced access by such means would be improper preferential access.

There is Alberta legislation prohibiting queue-jumping with respect to insured surgical services. The *Health Care Protection Act* provides as follows:

> 3. No person shall:
>
> (a) give or accept any money or other valuable consideration,
>
> (b) pay for or accept payment for enhanced medical goods or services or non-medical goods or services, or
>
> (c) provide an uninsured surgical service
>
> for the purpose of giving any person priority for the receipt of an insured surgical service.[19]

A person convicted of contravening this section faces a maximum fine of $10,000 for a first offence and a maximum of $20,000 for a second or subsequent offence.[20]

The statutory prohibition deals with financial incentives and only applies to giving priority to insured surgical services. There is no legislation or policy in effect to govern queue-jumping when no material benefit is offered, or governing the wide array of insured health services provided.

The limitations in the legislation can be contrasted with a similar queue-jumping prohibition enacted in Ontario in that province's *Commitment to the Future of Medicare Act, 2004*:

[19] R.S.A. 2000, c. H-1, s. 3.
[20] R.S.A. 2000, c. H-1, s. 26(3).

> 17. (1) No person or entity shall,
>
> (a) pay or confer a benefit upon any person or entity in exchange for conferring upon an insured person a preference in obtaining access to an insured service;
>
> (b) charge or accept payment or a benefit for conferring upon an insured person a preference in obtaining access to an insured service;
>
> (c) offer to do anything referred to in clause (a) or (b).[21]

The advantages to this prohibition are that it uses the term "confer a benefit," which arguably encompasses a wider variety of things than merely money or other valuable considerations. It also applies to an insured service, meaning all insured services under Ontario legislation, and it makes it an offence to offer to do any of the prohibited acts. Another advantage to the Ontario statute is that it includes a mandatory requirement for any prescribed person (which by regulation includes physicians, nurses, any person employed in a hospital who provides an insured service, or contractors performing insured services[22]) to report any violation of the statutory prohibition to the general manager of the plan appointed under Ontario's *Health Insurance Act*. The *Commitment to the Future of Medicare Act, 2004* also contains complementary protections against liability or employment retaliation for reports made in good faith.[23] The benefit of such provisions is self-evident.

[21] S.O. 2004, c. 5, s. 17(1).
[22] O. Reg. 288/04, s. 7.
[23] S.O. 2004, c. 5, ss. 17(2), (4) and (5).

Recommendation 1:

Strengthen the queue-jumping provisions of the *Health Care Protection Act*

The Government of Alberta should amend section 3 of the *Health Care Protection Act* to:

- broaden the scope of the prohibited forms of inducement;
- have it apply to all types of insured health services; and
- include a mandatory reporting requirement with provisions for the protection of people who make a report in good faith.

D. *Many ways into the system*

One of the major themes that emerged from the inquiry testimony was that there are multiple entry points into the health care system, each with its own opportunities for preferential access. That is, there are multiple ways to find out you are sick, and lots of ways into the system, all providing ways to get ahead in line. Given these circumstances, considering preferential access in one situation does not necessarily extend to another situation. The same rules may not apply at every point of entry. The following are some examples.

(i) Workers' compensation

Obvious examples are the provisions in the *Canada Health Act*[24] and the *Alberta Health Care Insurance Act*[25] excluding from the definition of insured services those services that a person is entitled to under federal or provincial workers' compensation legislation. The historical justification for special treatment of workers injured on the job is that it is better to have these people treated quickly so they can get back to work, rather than drawing compensation while waiting in a queue for treatment. Also, the compensation paid to injured workers usually comes from funds to which employers contribute, so there is pressure on workers' compensation boards to get workers treated quickly.

[24] S. 2.
[25] S. 1(n).

This exclusion, however, has led to what the Romanow report labelled a form of officially sanctioned queue-jumping.[26] Because these services are not considered insured services, workers' compensation boards can purchase them directly from hospitals and physicians rather than receiving them through the public health care system. This arrangement for workers almost inevitably leads to prompter access to health care. Despite this preferential service and access, and the fact that physicians and hospitals charge for these services, there is no jeopardy to a province's funding under the *Canada Health Act*.[27]

There is no doubt that this practice amounts to preferential access. But is it improper? Mr. Romanow thought so. He viewed it as being incompatible with the principle of equal access and argued that it should be reconsidered:

> … [T]he vast majority believe that all Canadians are equally entitled to timely service, regardless of their employment status. The elderly and children, for example, are just as deserving of prompt diagnosis as injured workers. For the same reasons that private payment for diagnostic services is contrary to the basic principle of medicare, this "public" form of queue-jumping should be redressed in a modernized *Canada Health Act*.[28]

The exclusion of injured people receiving workers' compensation benefits is a policy choice made by both levels of government. To my knowledge, no government has acted on Mr. Romanow's invitation to redress the inequality created thereby. It is proper preferential access only because duly elected legislators have accepted it. If, however, there is sufficient public disagreement with this policy choice, it may very well become improper preferential access. The ethical justification for this exclusion can only come from the fact that it is a democratically arrived-at policy choice.

[26] Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada: Final Report* (Ottawa, 2002) at 64-65.
[27] William Lahey, *The Legislative Framework Governing Access to Health Services that are "Insured Health Services" under the* Canada Health Act *and "Insured Services" under the Legislation of Alberta: A Report to the Health Services Preferential Access Inquiry of the Province of Alberta*, November 30, 2012, at 17 [Exhibit 11].
[28] Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada: Final Report* (Ottawa, 2002) at 8.

The exclusion of people entitled to receive workers' compensation benefits is only one of a long list of exclusions contained in the regulations enacted by the Alberta legislature[29] (and all other provinces and territories). Part of the rationale is a constitutional one since individuals who fall within the legislative competence of the Parliament of Canada cannot have their health care benefits restricted by provincial legislation. So individuals entitled to health care benefits under any of a list of federal statutes (such as military personnel and federal inmates) are excluded from the provincial system. But the result is that residents of Alberta who come within one of the excluded categories can receive preferential access to services through payment for those services because of their occupation or, as we see with workers' compensation claimants, the circumstances in which their injury or illness arose. Whether this distinction is proper is a matter of public choice as evidenced by the decisions of their elected representatives.

(ii) Private diagnostic imaging

Another example of an avenue into the system is private diagnostic imaging services, which may enable people to get diagnosed more quickly than under the publicly funded system. A person who purchases diagnostic imaging at a private facility, instead of waiting for the same service through publicly funded channels, receives the diagnosis more quickly. If the diagnosis indicates a need for treatment, that person can step into line for treatment. The person waiting for a diagnosis through the publicly funded system cannot step into line for treatment, since he or she has not received a diagnosis. Stepping outside the public system for diagnosis results in preferential access to treatment when one rejoins the public system.

Prof. Lahey traces the origins of this public-private dichotomy in diagnostic imaging services in his paper prepared for this inquiry.[30] There is no express mention of diagnostic services in the definition of insured health services in the *Canada Health Act*, but they come within its ambit in two ways. First, diagnostic procedures are a hospital service if they are provided to a hospital patient. Second, if they are ordered by

[29] See *Alberta Health Care Insurance Regulation*, Alta. Reg. 76/2006, s. 12; *Hospitalization Benefits Regulation*, Alta. Reg. 244/1990, s. 4(2).
[30] William Lahey, *The Legislative Framework Governing Access to Health Services that are "Insured Health Services" under the* Canada Health Act *and "Insured Services" under the Legislation of Alberta: A Report to the Health Services Preferential Access Inquiry of the Province of Alberta*, November 30, 2012, at 14-16 [Exhibit 11].

a physician as a medically required service, then they come within the scope of physician services under the definition of insured health services.

However, since the *Canada Health Act* came into force in 1984, developments in diagnostic technology and procedures have facilitated testing in private clinics outside of hospitals. But Health Canada took no steps to deal with diagnostic procedures purchased by or on behalf of a patient with no public funding involvement. This is in contrast to the threat by Health Canada to withhold federal funding to provinces that allowed facility fees or user charges to patients obtaining insured services. Prof. Lahey explained how privately funded diagnostic imaging can stand beside a publicly financed system. He said this can occur in two situations:

> In the first situation, the procedure is not thought to be strictly necessary from a medical point of view but the patient wants and is willing to pay for it nevertheless. This is a scenario that is more likely with some kinds of diagnostic procedures than it will be with other kinds of medical procedures. In the second situation, the procedure is medically necessary and therefore available through the public system but the patient is prepared and able to pay for it personally, usually to get it faster than he or she can get it in the public system. In that situation, the argument for regarding the service as being outside of the *Canada Health Act* is that the patient is paying to have the service more quickly than the public system, given factors such as prevailing waiting lists and clinical prioritization decisions, deems it to be medically necessary.… In both situations, there is a concern that privately funded access to a diagnostic procedure can result in preferential access in the public system to the treatments that the diagnostic procedure may reveal are indicated.[31]

The Romanow Commission considered this scenario to be incompatible with the principle of equitable access:

[31] William Lahey, *The Legislative Framework Governing Access to Health Services that are "Insured Health Services" under the* Canada Health Act *and "Insured Services" under the Legislation of Alberta: A Report to the Health Services Preferential Access Inquiry of the Province of Alberta,* November 30, 2012, at 15 [Exhibit 11].

> Medicare rests on the principle that an individual's financial resources should not determine access to services. In the Commission's view, governments have a responsibility to guarantee that the public system has sufficient resources to ensure appropriate access to advanced technology. Increased investment within the public system for new diagnostic technology can remove the temptation to "game" the system by individuals and health care providers through the private purchase of diagnostic tests that could allow them to jump the queue.[32]

Mr. Romanow recommended that all medically necessary diagnostic services be included explicitly in the definition of insured health services in the *Canada Health Act*. This recommended change to the Act has not been implemented.

There is no question that the temptation to use private diagnostic services can be great, even for people of modest means. Another of our expert witnesses, Mr. James Saunders, testified that in Alberta the standard wait time for a private MRI is inside of a week and a half, while the median wait time for a publicly funded MRI is 13 weeks for routine cases. Urgent cases would be seen faster.[33]

The proliferation of private diagnostic services poses a true ethical dilemma when considering it in the context of access to health care. It is possible to argue, as Mr. Romanow did, that this parallel private service should be banned for medically necessary testing. It undermines the principles of fairness and equity in access to health care and provides an advantage to those who can pay for this service.

On the other hand, the practice is not illegal. It is accepted by governments and by physicians' regulating bodies. Dr. Trevor Theman, the Registrar of the College of Physicians & Surgeons of Alberta, testified that the College worked with Alberta Health and AHS to ensure that the standards of diagnostic imaging were proper.[34]

[32] Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada: Final Report* (Ottawa, 2002) at 8.
[33] Testimony of James Saunders, Transcripts, vol. 2, December 3, 2012, at 115 and 132-33.
[34] Testimony of Trevor Theman, Transcripts, vol. 29, January 18, 2013, at 2309.

There may even be an ethical and legal obligation on a physician to advise a patient of the private option where the physician considers it to be in the interests of the patient.[35] I will discuss the ethical dilemmas for physicians later in this chapter when I discuss physician advocacy. For now, I want to give one example of the potential legal obligation that I mentioned earlier in this paragraph.

In the 1995 case of *Law Estate v. Simice*,[36] the British Columbia Court of Appeal upheld a finding of negligence against a physician who denied a CT scan to a patient because of his concern for cost containment. The patient died due to a burst cerebral aneurism. The Court recognized that governments and health boards make decisions about resource allocation, but physicians generally act as the gatekeepers of medical resources, as it is physicians who make the decisions regarding each patient's care. In this case the defendant doctor stated that he felt restricted in his ability to access diagnostic tests and tools because of the provincial health care plan's restrictive standards. The Court concluded unequivocally that health care providers must not allow cost containment considerations to inhibit their decisions as to whether otherwise necessary tests and procedures should be performed.

As a result, it is not inconceivable to argue that a physician could be found liable for not recommending a private option where it is available, as in Alberta. This liability could arise, for example, where insufficient resources and high demand produce long waits for publicly funded diagnostic procedures and the physician concludes that such testing is not only necessary but should be done as soon as possible. The law could in effect compel the physician to push his or her patient into private diagnostics.

Some will argue that the private option relieves pressure on the publicly funded service. That may be so in theory, but there is a lack of empirical evidence to substantiate the theory.[37] On the other hand,

[35] N. Cunningham *et al.*, "Ethics in Radiology: Wait Lists Queue Jumping" (2012) *Canadian Association of Radiologists J.* 1 at 4.
[36] (1995) 17 B.C.L.R. (3d) 1.
[37] The OECD found that incentives introduced in a number of countries to increase the use of the private sector and remove pressure from the public sector had mixed results and did not necessarily reduce wait times: L. Siciliani, M. Borowitz and V. Moran, eds., *Waiting Time Policies in the Health Sector: What Works?*, OECD Health Policy Studies (OECD Publishing, 2013) at 65.

some might well argue that the availability of private services merely relieves the pressure on government to add the public resources needed to satisfy the demand in a timely manner.

There is no correct answer, practically or ethically, in the debate over private diagnostic services. These services can reveal a patient's condition earlier than is the case with the patient's counterpart in the publicly funded system. Paying for a diagnostic test will put the private-option patient ahead in the queue for treatment – anathema to the goal of access to health care that does not depend on wealth.

Some might argue that the patient going to the private sector for an earlier diagnosis should not be allowed to profit from the advantage that his or her money bought. But one cannot ethically ignore a condition once it is diagnosed, even if the diagnosis was paid for privately. In any event, if the patient with the publicly funded test is later diagnosed with a more urgent condition than the private-option patient, that public-option patient will be moved ahead of the private-option patient.

Is the answer in effect to ban private diagnostic services by putting all such medically necessary services under the *Canada Health Act* as insured health services? This is a policy choice that has to be made with full knowledge of the ramifications. Would the public system be able to cope with the demand in a reasonable timely manner? I do not have the evidence to say one way or the other.

Publicly available information indicated that there are 15 private diagnostic services operating in 70 locations in Alberta. Diagnostic services are not, however, the only private services outside the provincial health insurance plan. Much more health care than that is being delivered outside of the traditional cores of the public system, hospitals and doctors' offices. Fewer important medical services are receiving public coverage. But once a serious condition is discovered through the private system and the patient has to return to the public system for treatment, the preferential access issue will arise again, as it did with privately paid diagnostics discussed above.

Private diagnostic and other services can lead to preferential access to treatment because they permit patients to circumvent the wait for publicly funded services. From an ethical perspective, looking at the principles underlying Canada's medicare system, this is improper. But

we do not operate in a purely ethical paradigm. These services are allowed and presumably have a measure of public acceptance. As long as policy decisions about these private diagnostic and other services are made in a transparent and democratic manner then I cannot label them as improper.

(iii) Medical tourism

Medical tourism also creates opportunities for preferential access. This phenomenon is not about going outside Canada to get treatment that is not available in Alberta. There is in Alberta an Out-of-Canada Health Services Committee that will consider requests for reimbursement of services beforehand if one has to go to another country for a service that might not be available in Canada.[38] Medical tourism means a person going out of the country to get services or tests that they could get here but which they choose to pay for and get faster elsewhere.

Several of the expert witnesses commented on the effect on access of medical tourism. Dr. Heisler said:

> In my practice, I'd have a patient go to the U.S. They're vacationing. They got a CT colonography done.… They now come back to me saying, "Here's my test. I have a polyp in my colon." So I know if there's a polyp in the colon, they've got an increased risk of cancer.[39]

Dr. Alter testified:

> There isn't a time, you know, during the week on call for a hospital service, for example, that you don't get a call from an insurance company trying to … get their patients who, by the way, are covered under their insurance policy and are vacationing down south back into the hospitals.[40]

Dr. Goldman commented:

> People are travelling to other parts of the world to get kidney transplants, hip replacements, the MS liberation treatment…. So these people get treatment. They return to Canada with a

[38] Testimony of James Saunders, Transcripts, vol. 2, December 3, 2012, at 118-19.
[39] Testimony of Owen Heisler, Transcripts, vol. 39, February 27, 2013, at 3417.
[40] Testimony of David Alter, Transcripts, vol. 39, February 27, 2013, at 3419.

> complication. And, to my knowledge, it has been articulated as an ethical obligation by Canadian physicians to provide care for those individuals. You can't say, "I'm sorry, you had your treatment elsewhere, go elsewhere."[41]

These descriptions highlight the dilemma that medical tourism poses for the health care system in Canada. The dilemma is similar to that resulting from access to private diagnostic services. Patients have the freedom to choose. If they choose to spend their money on services abroad, they are still Canadian residents and if their treatment abroad leads to complications later, they are entitled to publicly funded health services in Canada. They cannot, ethically or legally, be denied treatment or prioritized on a different basis than others who have completed their entire medical journey in the public health care system here.

The phenomenon of medical tourism is not in and of itself preferential access. Only if the publicly funded health care system in Alberta has to respond to the consequences of medical tourism could it become preferential access. But, because at that point there is medical necessity for the service, it cannot be labelled as improper.

These examples demonstrate that there are many ways to access the health care system and, more significantly, that preferences are built into the system. Some are built in by design – workers' compensation, for example. Other preferences are the by-product of medical tourism, private diagnostics or access to some other service through the private sector that eventually advantageously positions the patient at the doorstep of the public health care system.

E. *Socially justifiable preferences*

Is it acceptable for certain groups in society to receive preferential access? I imagine most people would say they already do, especially when referring to politicians, celebrities or athletes. But the question of status is much more multi-dimensional. People may defer to an important or famous person because there is a natural tendency to do so. The question in this section, however, is whether there can be categories of people who should receive preferential access because

[41] Testimony of Brian Goldman, Transcripts, vol. 38, February 26, 2013, at 3260.

society agrees they should or whether any such preference should be considered improper.

The question is really one of social acceptance or tolerance. The expert witnesses who appeared at this inquiry agreed that there likely is a level of tolerance within society for certain types of preferential access, but they emphasized the fact that this is another argument in favour of the need to engage the public in discussions surrounding issues related to health care. This engagement would allow the provision of health care to be aligned with societal values.

During the experts' testimony, I asked whether the prime minister of Canada should be dealt with immediately, regardless of the level of medical need, if he or she showed up at an emergency department. Dr. Reid answered from the ethicist's perspective:

> … the prime minister of Canada, I suppose, came up as an example. And maybe a hard-core egalitarian like myself might say that a good health care system is one where the prime minister of Canada is happy to receive care on the same terms and conditions as any other Canadian. That would be an ideal.[42]

Dr. Goldman emphasized the need to try to determine the public response to that question:

> You touched in a number of remarks on what the public would find acceptable. And I think that's a really important question to ask because I don't think the public should defer 100 percent to medical judgment. I think the public's footing the bill for medicare.
>
> The public has the right to decide that yes, we don't have a problem with the prime minister being given preferential access or we do have a problem with professional courtesy or we don't have a problem with professional courtesy. And I think these are scenarios that can be clarified with the public, and we can get some answers and some wisdom from them.

[42] Testimony of Lynette Reid, Transcripts, vol. 38, February 26, 2013, at 3293.

> I don't think the public wants to be in the business of deciding who should get the new hip or who should receive the latest chemotherapy drug, but there are other fundamental questions that I think the public should be consulted on.[43]

Despite agreement on the need for public input, Drs. Heisler, Reid and Alter pointed out that determining what social values are important and what is socially acceptable is inherently difficult. Dr. Reid stated, "society doesn't speak with one voice"[44] and "you can't run things on a majority opinion because minorities will be disadvantaged."[45] Dr. Heisler noted that the concept of ethical and moral correctness relates to an individual's perspective. "The challenge is when individuals say something is 'ethically' or 'morally' right this typically relates to their own unique perspective (most often shared within their local culture) which itself is often inconsistent as it is not unusual for individuals to flip-flop on paradigms."[46] Dr. Alter also stated, "The social acceptability has to be there, but we have to define what it is – what's the stakeholder perspective that we're actually anchoring."[47]

How to go about determining the public's attitude is problematic. Attempts have been made with some surprising results. A 2005 survey of Toronto households presented a list of different types of patients and asked who should be able to move ahead in line at an emergency department.[48] Respondents favoured triage based on medical need, but not status (indeed 20 per cent responded that a homeless person should be able to jump ahead of a government official or politician). The full results were as follows:

[43] Testimony of Brian Goldman, Transcripts, vol. 37, February 26, 2013, at 3189-90.
[44] Testimony of Lynette Reid, Transcripts, vol. 37, February 26, 2013, at 3188.
[45] Testimony of Lynette Reid, Transcripts, vol. 37, February 26, 2013, at 3220.
[46] Exhibit 149, Expert Reports, report of Dr. Owen Heisler (January 2013) at 2.
[47] Testimony of David Alter, Transcripts, vol. 39, February 27, 2013, at 3394.
[48] Steven Marc Friedman, Lee Schofield & Sam Turkos, "Do as I say, not as I do: a survey of public impressions of queue-jumping and preferential access" (2007) 14 *Eur. J. of Emergency Medicine* 260 at 262.

Which of the following people should be able to jump ahead in the waiting line in the Emergency Department? (Y/N)

Patient demographic	Yes (percent)
Person with a medical emergency	100
Person in severe pain	90
An infant or child	83
Police officer on duty	50
Homeless person	20
Doctor	12
Hospital benefactor or philanthropist	12
Hospital administrator	6
Religious leader	5
American (paying U.S. $)	5
Government official or politician	3
Celebrity	0

There may indeed be broad social tolerance for certain people receiving preferential access provided, of course, that no one with a life-threatening condition is bumped out of line. The leaders of the government might be one category. Another category might be patients enrolled in research protocols (considering the ultimate benefits to be gained from such research). The level of public tolerance may not be so high for athletes or other celebrities.

Tied to the idea of social acceptability is the concept of an individual's or profession's social utility or value. In this area the expert witnesses disagreed as to what extent the examples of medical professionals or first responders receiving expedited care constituted proper or improper preferential access and where the boundaries of social acceptability lay. Dr. Alter pointed out that professional courtesy, allowing preferential access to health care for doctors, nurses and other health care providers, may be considered an example of proper preferential access because of social utility,[49] while Dr. Reid contended that social utility or social value was "rarely, if ever, an ethically justifiable criteria for access."[50] In her written submission, Dr. Reid defined social value as "status-

[49] Testimony of David Alter, Transcripts, vol. 40, February 27, 2013, at 3444.
[50] Exhibit 149, Expert Reports, report of Dr. Lynette Reid (February 15, 2013) at 10.

based or tied to particular conceptions of greater or lesser human value."[51]

A good argument can be made that front-line health care workers, in a situation of urgent circumstances such as a pandemic, should be inoculated first along with their families (on the theory that sick family members will compel the health care workers to leave their duties to care for the family members). Similarly, in civil emergency circumstances, police and firefighters should be given priority. Such incidents of preferential access would not be regarded as improper.

There are other essential services that are much more up for debate for gaining preferential access because of their role in society. Dr. Goldman suggested that "society has to decide what are essential services and what aren't" in relation to the discussion of the social utility of different professions.[52] Again, Dr. Reid cautioned:

> Where scarce resources are allocated on the basis of social need (or society's medical needs), a careful, transparent and multi-dimensional assessment should be made to ensure that a fair judgment is made about who is at risk (e.g. are teachers or transit workers also highly exposed?) and who is essential (e.g. are hospital housekeeping staff also essential workers?), and who is not (e.g. is an administrator who works offsite during an outbreak especially at risk?).[53]

There has to be a clear definition of what constitutes an essential service and in what circumstances. This can only be achieved through a collaborative effort involving health care professionals and administrators, government officials and the public.

F. *Physician advocacy and ethics*

Advocating for the health of the individual patient is a basic function of a physician. It is one of the fundamental competencies for physicians identified by the Royal College of Physicians and Surgeons of Canada.[54] The Canadian Medical Association Code of Ethics has, as a

[51] Exhibit 149, Expert Reports, report of Dr. Lynette Reid (February 15, 2013) at 10.
[52] Testimony of Brian Goldman, Transcripts, vol. 38, February 26, 2013, at 3284.
[53] Exhibit 149, Expert Reports, report of Dr. Lynette Reid (February 15, 2013) at 26.
[54] "Canadian Medical Education Directions for Specialists" (The CanMEDS Framework), available at www.royalcollege.ca/canmeds/framework.

fundamental responsibility of physicians, to "consider first the well-being of the patient."[55]

There is, however, an ethical tension created by the Code of Ethics. While a physician has a primary responsibility to the patient, there is also a fundamental responsibility to "consider the well-being of society in matters affecting health"[56] and specific duties to "promote equitable access to health care resources,"[57] to provide services without discrimination on a number of grounds, including socio-economic status,[58] and to "use health care resources prudently."[59]

This tension between advocacy for the specific patient and the interests of the community was highlighted by some of the expert witnesses. It is highly complex because when advocating for the well-being of the individual patient, physicians may be simultaneously at odds with advocating for the health of others in the community or population. Physicians are taught to be advocates for their patients but, as Dr. Heisler said, "you do need to have responsibility to a population as well."[60]

Balancing the needs of the individual patient versus advocating for your patient population is difficult. Dr. Heisler stated, "Unless you can monitor the outcomes of the whole population or the panel of patients that a given individual is seeing, it's hard to sort out and say, 'Well, you're not advocating hard enough.'"[61] Prof. Reid expanded on the spectrum of advocacy: "Without a lot of touchstones for what's fair or not fair in the system as a whole, some physicians might take the responsibility of advocacy more towards the end of doing everything possible to get your own individual patient as fast as possible access to the best services, as opposed to getting them fair access to services that anyone would have a right to. So that's kind of somewhere in there. I'm not saying it's black and white. It's absolutely grey and a continuum."[62]

[55] Canadian Medical Association, *Code of Ethics* (Update 2004), art. 1.
[56] Canadian Medical Association, *Code of Ethics* (Update 2004), art. 4.
[57] Canadian Medical Association, *Code of Ethics* (Update 2004), art. 43.
[58] Canadian Medical Association, *Code of Ethics* (Update 2004), art. 17.
[59] Canadian Medical Association, *Code of Ethics* (Update 2004), art. 44.
[60] Testimony of Owen Heisler, Transcripts, vol. 40, February 27, 2013, at 3454.
[61] Testimony of Owen Heisler, Transcripts, vol. 40, February 27, 2013, at 3455.
[62] Testimony of Lynette Reid, Transcripts, vol. 38, February 26, 2013, at 3252.

Dr. Alter presented his view of balancing individual patients and societal needs when treating patients: "I mean as docs, we advocate for our patients for a variety of reasons. They are our primary stakeholder. When I'm at a bedside, I'm not thinking about the health system and the cost effectiveness. That's for allocation. I'm thinking about the individual, and all of these individual social needs do come into play."[63]

Physicians are expected to perform a balancing act with multi-dimensional decisions every day and with every patient. Dr. Heisler noted, "So it's a balance not only of your responsibilities but of your obligations and your rights within a society that you need to balance. So that's the point I'm making here is this is a massive balancing act that is really hard to codify in books because, as has been said by colleagues, every patient is very individual and unique…. And that's your challenge with medical need. It's not just the patient. It's a whole lot of other issues that are often involved."[64]

Some physicians are more effective and enthusiastic advocates for their patients than others. The question was put to the expert witnesses: "What do we do with the fact that physicians will vary, sometimes widely, in their ability to advocate for their patients or their effectiveness?"[65] Dr. Alter replied, "Absolutely. Some physicians advocate more strongly for patients than others."[66] Dr. Heisler described how he handles calls from some physicians versus others, expanding on the fact that individual abilities to advocate for patients is complicated by the referring physician's ability to deal with different medical conditions. "Some are really comfortable doing things, some aren't. So when some docs called me about something, I saw that person the next day because I know they called only when it's really bad and they've tried everything. There are other people that I would give them some coaching. 'Have you tried this?' 'Have you done that as a go-forward?'"[67]

When asked whether there was room for processes to provide clarity on issues such as advocacy, Dr. Heisler said, "So the short answer is yes. I think that one of the responsibilities of a self-regulating profession is

[63] Testimony of David Alter, Transcripts, vol. 39, February 27, 2013, at 3395.
[64] Testimony of Owen Heisler, Transcripts, vol. 39, February 27, 2013, at 3385.
[65] Question by Commission counsel, Transcripts, vol. 40, February 27, 2013, at 3450.
[66] Testimony of David Alter, Transcripts, vol. 40, February 27, 2013, at 3452.
[67] Testimony of Owen Heisler, Transcripts, vol. 40, February 27, 2013, at 3454-55.

the responsibility to manage things of the nature that you [the Commissioner] spoke of."[68] Dr. Heisler continued, "I do think that there is an opportunity for regulatory bodies of whichever nature to help in establishing what that [advocacy] might look like."[69] Dr. Alter said, "I do think there are…regulatory bodies that can help form and clarify."[70]

Ethical advocacy, that being advocacy to ensure that patients receive the care that is due to them, based on their medical needs, cannot be regarded as facilitating improper preferential access. It is the proper role of the physician. But as I have already noted in the excerpts quoted from the testimony, it is a complex exercise, with competing ethical responsibilities, and one that not all physicians are equally equipped to carry out.

In its 2012 report, the HQCA conducted an extensive review and survey of physicians in Alberta on the subject of advocacy. It reported several significant findings:

- 56 per cent of physicians surveyed reported that their ability to advocate is limited by unclear processes for advocacy;
- 37 per cent were not aware of a process for advocacy;
- 69 per cent reported no formal training in advocacy;
- 20 per cent of physicians who advocated experienced "active harmful obstruction;"
- 51 per cent felt their ability to advocate had been limited; and
- many of the physicians interviewed also reported experiencing intimidation of themselves or colleagues as a result of advocacy.[71]

Many of these comments related specifically to attempts by physicians to advocate for patients whose quality of care they believed could be compromised due to system resources or policies. But the fact that such

[68] Testimony of Owen Heisler, Transcripts, vol. 40, February 27, 2013, at 3462.
[69] Testimony of Owen Heisler, Transcripts, vol. 40, February 27, 2013, at 3463.
[70] Testimony of David Alter, Transcripts, vol. 40, February 27, 2013, at 3463.
[71] Health Quality Council of Alberta, *Review of the Quality of Care and Safety of Patients Requiring Access to Emergency Department Care and Cancer Surgery and the Role and Process of Physician Advocacy* (February 2012) at 28-30.

a high proportion of respondents reported no formal training or knowledge of any process for advocacy is quite concerning, having regard to the ethical mandate to advocate.

The HQCA went on to make three specific recommendations on the subject:

1. (That) Alberta Health Services, in collaboration with Alberta universities, the Alberta Medical Association, the College of Physician & Surgeons of Alberta, and other organizations develop and implement clear policies and procedures to guide physicians on how to ethically, appropriately, responsibly, and effectively advocate;

2. (That) Alberta Health Services, Alberta universities, the Alberta Medical Association, the College of Physicians & Surgeons of Alberta, and other organizations explore the need for and feasibility of a provincial independent process for physicians who, despite exhausting all internal processes, believe their advocacy efforts have not been adequately addressed; and

3. (That) the faculties of medicine in Alberta ensure that the Royal College of Physicians and Surgeons of Canada CanMEDS 2005 physician competency framework be the foundation for an advocacy curriculum for undergraduates and postgraduates and that it be made available for continuing medical education.[72]

I express my complete support for these recommendations and reiterate the importance of acting on them. Education on the principles of ethical advocacy and development of clear guidelines will go a long way in eliminating the circumstances that may lead to incidents of improper preferential access.

There is a further recommendation that I have considered at the urging of a number of the parties who appeared at the inquiry.

[72] Health Quality Council of Alberta, *Review of the Quality of Care and Safety of Patients Requiring Access to Emergency Department Care and Cancer Surgery and the Role and Process of Physician Advocacy* (February 2012) at 193-94.

The government recently enacted what is commonly referred to as whistleblower legislation.[73] That statute applies only to employees of the government or a public entity. It does not apply to independent contractors such as physicians or other health care providers, yet their careers may be equally at risk without whistleblower protection. Such a provision would give added safety to professionals in the health care system who speak out about resource or policy issues or challenge improper procedures.

Recommendation 2:

Expand whistleblower protection

The Government of Alberta should amend the *Public Interest Disclosure (Whistleblower Protection) Act* to include health care professionals, such as physicians, who are not employees but who are contracted by Alberta Health Services and/or the government to provide health care services.

G. *Professional courtesy*

There was evidence before the inquiry about the concept of professional courtesy, where physicians in particular give priority to requests for care by other physicians, health care workers and their families. It is a commonly accepted practice, with deep roots in medical practice. Professional courtesy is therefore another entry point into the health care system. Significantly, however, it is not available generally to the public since it is a matter of physician discretion. Professional courtesy therefore produces a form of preferential access.

At one time, professional courtesy consisted of a physician providing medical care to colleagues or their families for free or at a reduced rate. This is still how professional courtesy manifests itself in the United States.[74] In part, it arose because of the ethical limitations on treating oneself (for example, by writing oneself a prescription) and one's family members.[75] In part it is an expression of professional solidarity.

[73] *Public Interest Disclosure (Whistleblower Protection) Act*, S.A. 2012, c. P-39.5.
[74] See American Medical Association, *Code of Medical Ethics*, Opinion 6.13 – Professional Courtesy.
[75] In the Canadian context, see, for example, the Canadian Medical Association, *Code of Ethics* (Update 2004), art. 20.

In Canada today, where health services are generally publicly funded, professional courtesy is not about waiving or discounting a fee. Instead, it is about accommodating requests for consultations. Professional courtesy has come to mean seeing a colleague or their family member more quickly than would occur if they were a typical patient. This is done by seeing them outside regular hours.

The clinicians who testified at this inquiry, including those who appeared as expert witnesses, expressed the view that this is an acceptable practice, provided it did not bump another patient waiting in line, and that it is therefore not preferential access.[76] One of our expert witnesses, Dr. Lynette Reid, disagreed. She argued that professional courtesy was nothing more than insider privilege and could impede access to the system by others.[77] Even if no other patient is bumped from a physician's wait list when the physician agrees to see a colleague after work, it will damage the health care system as a whole if the practice is sufficiently prevalent. With about 75,000 physicians and a quarter-million nurses in Canada, Dr. Reid noted, "this is not a small number of people…. And so I would doubt that any form of queue-jumping for insiders to the health care system would not affect care to others in a substantial way."[78]

As I noted previously, professional courtesy is not associated with waiving or discounting fees in Canada. Physicians seeing other health care professionals or their family members can and do charge the Alberta health insurance plan for these consultations.[79]

Although professional courtesy is very much a part of medical culture, there seems to be no consensus on how wide the net of professional courtesy should be cast.

Dr. Trevor Theman, the Alberta College registrar, viewed professional courtesy as extending to other health care professionals, but he did not know of a commonly accepted definition. He thought it might be broad enough to encompass people with whom physicians work on a regular basis but who are not necessarily themselves health care providers – for

[76] See, for example, the testimony of Brian Goldman, Transcripts, vol. 38, February 26, 2013, at 3246-47.
[77] Testimony of Lynette Reid, Transcripts, vol. 38, February 26, 2013, at 3253-54.
[78] Testimony of Lynette Reid, Transcripts, vol. 38, February 26, 2013, at 3255.
[79] See, for example, the testimony of Trevor Theman, Transcripts, vol. 29, January 18, 2013, at 2355.

example, a clinic manager or someone who the physician sees at the request of another physician. He said he would not be surprised if some physicians considered professional courtesy to include friends.[80]

Dr. Nicholas Mohtadi testified that in his practice he is often asked to see a particular person as a favour and does so. These requests might come from friends or people affiliated with organizations that he works with (such as the University of Calgary, where he maintains a sports medicine clinic and holds an appointment as a clinical professor). The people he sees might be athletes, a university donor or someone else who might be important in that environment.[81]

Dr. Raj Sherman testified about how he, as a member of the legislature, helped his MLA colleagues avoid long waits for a doctor's appointment by assisting them with simple prescription refills and treatment for minor complaints. He said he did this in his MLA office and he described this activity as professional courtesy.[82]

As can be seen from such testimony, professional courtesy is a very elastic concept. Dr. Theman acknowledged that there is nothing in the College's Standards of Practice or the Code of Ethics regulating professional courtesy. Nor was he aware of any instance where a college of physicians and surgeons elsewhere had attempted to regulate it.[83] To him, as well as to the other physician witnesses, exercising professional courtesy was a matter of discretion for the individual physician:

> I think the practice of medicine, like many areas in health care, has the expectation that our members will use discretion, that they will act wisely. To a degree, we can create some guidance, but regulating some kinds of behaviour is very difficult. And when we get to ethical decision-making, in particular, one often needs to understand all of the facts that surround it to know whether that was a reasonable thing or not a reasonable thing …. [I]t's very difficult, then, to write rules, except for those extreme situations, that this you must not do, but it

[80] Testimony of Trevor Theman, Transcripts, vol. 29, January 18, 2013, at 2346-60 and 2368.
[81] Testimony of Nicholas Mohtadi, Transcripts, vol. 17, January 10, 2013, at 1340-41 and 1362.
[82] Testimony of Raj Sherman, Transcripts, vol. 12, December 13, 2012, at 856-860.
[83] Testimony of Trevor Theman, Transcripts, vol. 29, January 18, 2013, at 2347, 2367.

> becomes much more difficult in those grey areas or those areas of discretion where I think discretion is reasonable.[84]

I also heard evidence about professional courtesy as a justification for providing priority access to care for doctors, nurses, other health care workers, and their families in emergency departments.

Mr. Donald Christensen is an area manager for the Sheldon Chumir Urgent Care Centre. He was asked to describe the expectations about professional courtesy within the Centre:

> If an urgent care staff member came to work and they had a sore throat or they had a sore back or they had a minor sprain to the ankle, they would have a conversation with one of the physicians working. The discussion would be [to] generate a chart, so triage chart generation; take it directly back to the physician, and the physician and the employee would do a quick medical assessment. If they needed a throat swab or if they needed an x-ray, it would be ordered at that time. The tests would be completed. The person – the employee – would be back to work, and the physician would be taken out of service for a very short period of time. So that is not new to our business.[85]

Mr. Christensen said this practice was once considered professional courtesy, but no longer. As a member of the provincial urgent care executive, he said an item was put on the agenda for the September 2012 urgent care committee meeting, to discuss access by staff members to urgent care services. The discussion at the meeting, held on September 18, was brief and direct. As he testified before the inquiry, "We all knew that this process was happening, and it was no longer considered professional courtesy. It was considered a form of queue-jumping and that we were to cease and desist this behaviour immediately." All managers then returned to their respective teams to discuss with their staff how to stop this behaviour.[86]

Mr. Christensen said he was initially advised (he did not indicate by whom) not to do a written communication about this. He accepted this advice until he had "hints" that some people were still attempting to get

[84] Testimony of Trevor Theman, Transcripts, vol. 29, January 18, 2013, at 2360.
[85] Testimony of Donald Christensen, Transcripts, vol. 8, December 10, 2012, at 539.
[86] Testimony of Donald Christensen, Transcripts, vol. 8, December 10, 2012, at 539-40.

preferential access, but it was being stopped either at triage or by the charge nurses. That is when he sent an email on October 11, 2012, requesting all staff stop this behaviour. The email reads in part:

> AHS [has] **zero tolerance** for preferential treatment and/or queue-jumping. I trust that none of you would ever put yourself in the situation where you would request that one of our UCC physicians would see you out of order based on CTAS [Canadian Triage and Acuity Scale] score and existing REDIS [a tracking system] priority number.
>
> My expectation is that if you are sick enough to require physician attention while at work, then you are no longer able to function in the role of a staff member and you become a patient of the UCC, obtaining a CTAS score from triage and an appropriate REDIS priority number based on presenting complaint and that you wait your turn to be seen by one of the physicians.[87]

Mr. Christensen was asked if he had any experience with doctors trying to expedite treatment of their own families or friends. He had, but their attempts were unsuccessful. Physicians would bring family members in and present them for triage and ask the triage nurse to make a chart so that they could speak to whomever was working in urgent care. The triage nurse would be very clear that if physicians want their children examined, they must follow procedure.[88]

Mr. Kyle Cridland performs a number of nursing roles at the Calgary Foothills Emergency Department, including acting as a triage nurse. He was asked how doctors, nurses and their families are treated when they come to the emergency department:

> [T]ypically if a colleague shows up … [who] needs medical attention [for themselves] or a family member, we will triage them accordingly; give them their proper acuity score. And then, generally speaking, we will do one of two things: Either bump them up in the priority level … so they get seen quicker, or we will go and find an emergency doctor and just say,

[87] Exhibit 32 [emphasis in original].
[88] Testimony of Donald Christensen, Transcripts, vol. 8, December 10, 2012, at 544-45.

> "Hey, this person so-and-so is here. Do you mind seeing them just when you have a minute?"[89]

Mr. Cridland had seen colleagues come in the front door, wait in line with everyone else and get triaged. Sometimes colleagues will come through a back door and "kind of just come up to triage quietly and say, 'Hey, I'm here. Can you triage me?'" Staff who become injured or ill while on shift would simply report to triage and identify the problem. However, sometimes when workers get injured at work in the hospital, they come through the front door and wait like everyone else.[90]

Mr. Cridland explained that, when moving a patient ahead in the queue, they might be put to the front of the queue of those at the same acuity level. They would not be moved ahead of anyone with a higher acuity level.[91]

Dr. Francois Paul Belanger is senior vice-president and zone medical director for the Calgary zone. He also has a clinical practice as a pediatric emergency physician at the Alberta Children's Hospital and South Health Campus.

Dr. Belanger was asked if, in his experience as a physician in the emergency room of the Children's Hospital, staff or family of staff can be seen more quickly. He replied that he had seen this happen on occasion, but that in such situations it was more often the staff's children rather than the staff members themselves who were the patients. He said that in his experience, the children of staff or family of staff were sometimes seen faster in the emergency room. This happened not at the demand of staff, but as a matter of professional courtesy.[92]

The expert witnesses who testified at the inquiry deemed the provision of priority access through the emergency department to be preferential access, but disagreed somewhat as to whether it was improper. Dr. Heisler wrote, "It is incumbent on all health care workers to appropriately utilize the emergency department and work within the system to ensure that the ED is appropriately utilized for emergency

[89] Testimony of Kyle Cridland, Transcripts, vol. 31, February 19, 2013, at 2505.
[90] Testimony of Kyle Cridland, Transcripts, vol. 31, February 19, 2013, at 2505.
[91] Testimony of Kyle Cridland, Transcripts, vol. 31, February 19, 2013, at 2512.
[92] Testimony of Francois Belanger, Transcripts, vol. 26, January 16, 2013, at 2176.

and urgent care – not as a way to facilitate more rapid access to care."[93] Drs. Goldman and Alter agreed that the practice was preferential access, but did not explicitly deem it improper. Dr. Goldman wrote that he believed it would be "churlish" to deny physicians the right to provide special access to colleagues and that "the same courtesy should be extended to immediate family members of a colleague."[94] Dr. Church wrote that allowing access through the emergency department was appropriate "if clear criteria for medical necessity and severity of illness relative to other patients in the emergency room at the time were met."[95]

I agree with those witnesses who describe priority access for health care professionals to emergency department service as improper preferential access, even if one labels it as merely professional courtesy. The only exception I can think of would be the case of an essential worker where failure to expedite care for that worker would prevent them from carrying out their duties and would place others in danger. But there should be clearly defined protocols for these circumstances. I am also confident that health care staff injured on the job can be treated in the normal emergency department manner, barring unusual circumstances, without an impact on the functioning of the organization.

Emergency departments are arguably a special category when considering the extent of professional courtesy. But what about the usual situation where a physician will see someone outside their regular hours?

The Alberta Medical Association gave a vigorous defence of professional courtesy in its submissions to the inquiry. It argued that there is nothing improper or unethical because all it does is give another entry point into the queue. If further treatment is required, the patient is simply put into the system and prioritized according to his or her medical acuity. The Association's position was that this was no different than the situation where a patient might be seen faster by a specialist when that patient's physician is able to write a more fulsome referral letter.

[93] Exhibit 149, Expert Reports, report of Dr. Owen Heisler (Supplementary Questions, February 2013) at 1.
[94] Exhibit 149, Expert Reports, report of Dr. Brian Goldman (February 7, 2013) at 6; see also Expert Reports, report of Dr. David Alter (February 7, 2013) at 6.
[95] Exhibit 149, Expert Reports, report of Dr. John Church (February 15, 2013) at 5.

The difficulty with this argument, of course, is that a physician can be trained to write better referrals. However, it is impossible to learn how to be in a special relationship where courtesies or favours are extended. A person either has insider status or he or she does not. It also ignores the clear evidence about lengthy wait times from the referral to the consultation with the specialist or for diagnostic tests. To say that the queue starts only when the specialist has determined that something further needs to be done ignores the reality for the vast majority of Canadians. Dr. Mohtadi acknowledged quite frankly that what he does under the label of professional courtesy is preferential access.[96]

The majority of the expert witnesses agreed that providing service to friends and colleagues, if it is done outside normal office hours, is a proper form of preferential access.[97] Some viewed it as an issue of physician autonomy and the responsibility physicians exercise in organizing their practices.[98]

Dr. Reid analyzed the question within the framework of the Canadian publicly funded system and submitted that the insider access provided to health care professionals and their families under the guise of professional courtesy is ethically unjustifiable. She expressed the following opinion in her testimony:

> There may be this history of physicians providing care for one another without pay before the system was a public pay system. We now are in a situation where physicians have direct access to and control over a taxpayer-funded service which is a service that's not just like any other taxpayer-funded service but particularly important to each one of us individually – health and health care. And I have a hard time seeing people who are insiders to that system deciding that they themselves have a particular call on quicker access within that system as anything but improper.[99]

[96] Testimony of Nicholas Mohtadi, Transcripts, vol. 17, January 10, 2013, at 1364.
[97] Exhibit 149, Expert Reports, report of Dr. David Alter (February 7, 2013) at 8-9; Exhibit 149, Expert Reports, report of Dr. Owen Heisler (Supplementary Questions, February 2013) at 2-3.
[98] Exhibit 149, Expert Reports, report of Dr. Brian Goldman (February 7, 2013) at 7; see also Exhibit 149, Expert Reports, report of Ms. Pam Whitnack (undated) at 6-7.
[99] Testimony of Lynette Reid, Transcripts, vol. 38, February 26, 2013, at 3253-54.

In answer to the argument that nobody waiting on a specialist's referral is prejudiced because the specialist is choosing to see the "courtesy" patients outside regular office hours, Dr. Reid responded that because the system is chaotic it is not easy to identify who is being bumped or disadvantaged by this practice. She stated:

> I have a hard time kind of squaring a wheel on this one to see where you could offer someone closer access or preferential access to a publicly funded necessary service because of a relationship they have with you, a personal relationship they have with you, that would not be in and of itself raise questions about harm, about appropriate management of a public resource.[100]

Dr. Reid also highlighted a systemic objection to professional courtesy, that being the disincentive to insiders to effect change in the system: "The people who are considering and contemplating preferential access, in a sense queue-jumping, the insider privilege … are the people who, if anyone, (are) in a position of power to change the system," she said. "A widespread practice of jumping the queues means that they're not confronting the problem themselves." That means they are not experiencing the same access troubles as most Canadians: "When everyone is in the same boat and everyone experiences the same access, then … those with voice and power in the system have more of an incentive to see to its good functioning."[101]

I recognize the attraction of the concept of professional courtesy to the professionals. I have no doubt that all doctors consider it an honour to care for other doctors and their health care colleagues. Professional courtesy can help solidify bonds between physicians and working relationships. There are also practical arguments in favour of the practice.

In support of professional courtesy, Dr. Goldman put forward the idea that physicians have "aggravated or exaggerated apprehensions" when it comes to their own health, because of their intimate medical knowledge. They are more susceptible to fearing the worst-case scenario at the first sign of a symptom than perhaps a regular patient might be. Whereas a physician might spare a patient unnecessary

[100] Testimony of Lynette Reid, Transcripts, vol. 38, February 26, 2013, at 3297-98.
[101] Testimony of Lynette Reid, Transcripts, vol. 38, February 26, 2013, at 3256-57.

anguish until a diagnosis can be made, a physician, noticing a symptom in himself or herself, does not have that option. In such a situation, Dr. Goldman opined, "It would be cruel to make the physician, who instantly knows that they could be dealing with a death sentence, wait and wait and wait and wait."[102]

In a 2012 publication the president of the Calgary and Area Medical Staff Society, Dr. Lloyd Maybaum, defended professional courtesy as a way of avoiding distractions for physicians:

> Now let us ponder what would happen if we did not have professional courtesy. You now have a physician that has an ill family member and they must wait six months to see the specialist. They are now increasingly distracted, anxious and stressed as they run their loved ones back and forth to appointments forcing them to curtail or even miss work. The increasingly distracted physician can lead to delays in work and the lengthening of wait times for all of his or her patients. Perhaps more alarmingly, we are forbidden by the College of Physicians and Surgeons to treat our own family members. Thus, without professional courtesy one can imagine how all the more tempting it would be to take matters into our own hands and treat our own family members in order to avoid all the hassles one might otherwise encounter.[103]

There are also professional and personal arguments against the practice. Over 30 years ago, two medical professors outlined the disadvantages extensively in an article published by the American Academy of Pediatrics:

> There are numerous disadvantages inherent in the care of physicians and their families. Physician-patients and their spouses are slow or even reluctant to seek health care. Many feel it is an imposition or that they should be able to care for their own complaints. There are gaps and variations in record keeping. A parent or patient-physician may have special but hidden anxieties in view of his medical knowledge. The treating physician may rely on the patient-physician for part or all of the diagnosis and treatment. Self-referral and self-treatment are

[102] Testimony of Brian Goldman, Transcripts, vol. 38, February 26, 2013, at 3250.
[103] Calgary and Area Medical Staff Society, *Vital Signs* (November 2012) at 7.

> common. History taking may occur in the hospital corridor or at cocktail parties. The treating physician may treat not only anxiously but more cautiously if he feels under scrutiny. The patient-physician may feel unable to complain about care or be reluctant to change physicians. In general, both treating- and patient-physicians are more likely to behave in ways that are contrary to or deviate from the behaviors prescribed by their traditional roles. Carey and Sibinga state that treating families of your social friends carries with it the disadvantage of (1) unrealistic expectation and hidden motivations, (2) trouble keeping social and medical relationships separate, (3) difficulty handling dissatisfaction on the part of both parties involved. There are the advantages to the physician-patient of (1) knowing more about who is competent and (2) being able to seek competent attention promptly, but these advantages are far outweighed by the above mentioned disadvantages. Although professional courtesy is not necessarily the sole underlying difficulty, its role is instrumental in allowing the above disadvantages to occur.[104]

These itemized disadvantages to the practice of professional courtesy may or may not be present in every circumstance. They are primarily psychological, as are the purported advantages. But professional courtesy raises a broader concern, one like the availability of private diagnostic services. An individual, for reasons other than just medical need, gains access to a service far sooner than others. In one case, it is because of who they are or who they know; in the other, it is their financial means. Then, if further treatment is required, that person is placed on a priority list, admittedly according to his or her medical acuity, but before those who are still waiting to be diagnosed. The fact that the speedy consultations are done outside regular hours seems to me to be irrelevant to this fact. Access through professional courtesy is undoubtedly preferential access.

I accept that physicians are under an ethical duty preventing them from treating themselves or their family members. They must get care from others. So I can also accept that professional courtesy can and should encompass services by one physician to another. In practical terms, that

[104] L.W. Bass & J.H. Wolfson, "Professional Courtesy" (1980), 65 *Pediatrics* 751 at 755, referencing Carey and Sibinga, "Should you provide pediatric care to your friends?" (1968), 42 *Pediatrics* (106).

usually means a direct and personal referral. I do not consider this to be improper. I would include in this professional colleagues, such as nurses. But the real question is how widely this practice should apply.

I see no justification in labelling as professional courtesy consultations conducted as favours for friends or other contacts. That does beg the question of a two-tiered system (particularly since those services are still charged to the public system). There is no ethical rationale, as in the case of physicians, for extending preferential accommodation to others – at least not under the pretext of professional courtesy. Furthermore, while personal and professional loyalties may be positive values in some contexts, requests for preferential access can pose an ethical dilemma for the health care provider and even create a conflict of interest.

The Alberta Medical Association, as well as the physicians who testified at the inquiry, were strongly opposed to any type of regulation that might limit the exercise of a physician's discretion to decide how professional courtesy is to be extended. But I think there is a role for regulatory bodies to play in bringing some definition and clarity to the boundaries of professional courtesy.

Recommendation 3:

Clarify the scope and application of professional courtesy

The College of Physicians & Surgeons of Alberta, working with the Alberta Medical Association, the College & Association of Registered Nurses of Alberta and other representative bodies, as well as public representatives, should closely examine the practice and ethical implications of professional courtesy with a view to defining its scope and application and providing guidelines to health care professionals.

H. *Increased clarity on access issues*

Another recommendation suggested by a number of parties was to promote education about these issues. Several of the expert witnesses commented on how issues of professional courtesy and improper access should be part of the curriculum of medical and nursing schools. I agree. But the lead must be taken by the regulators and professional associations. They are the ones that set the standards of practice.

Dr. Reid pointed out that medical and nursing students are exposed to two sources of information – what is taught in the classroom and what they see around them in practice: "So education of future practitioners is always a one-sided approach and insufficient. If you don't change actual practice, students don't believe what you're saying."[105] Dr. Goldman added that there is a concept in medicine called "the hidden curriculum." This is the gap between what is taught and what is learned. "Learners learn very quickly that solidarity with their colleagues may involve sticking together, an us-versus-them policy, attitude, and … that might include professional courtesy as well."[106]

At the beginning of this report, I quoted Dr. John Church's distinction between equality of access and equity of access. He defined the latter as "ensuring that patients who have the same medical conditions have the same opportunity to access the same services."[107]

There are many reasons why everybody does not have the same opportunity to access health services. But who you are or who you know should not be one of those reasons. If there is to be equity of access, then the impediments to that should be identified and set forth in a transparent and definable manner. Hence, my recommendation for clarity and guidance from the regulators and professional associations with respect to professional courtesy, as well as my reinforcement of the HQCA's recommendations about physician advocacy.

I. *A proposed definition*

As the previous discussion in this chapter illustrates, there is a multi-dimensional nature to the issue of improper preferential access. There are preferences that are built into the system through legislation. There is the opportunity of preferential access through circumventing wait lists for diagnostic procedures by resorting to the private system. There is a similar opportunity to circumvent the wait to see a specialist by a physician's discretion to extend professional courtesy, however she or he may define it. Whether any of these are improper is something that cannot be decided without knowing the context.

In only one instance can it be said definitively that an act is improper preferential access. That would be the type of conduct prohibited by

[105] Testimony of Lynette Reid, Transcripts, vol. 38, February 26, 2013, at 3320.
[106] Testimony of Brian Goldman, Transcripts, vol. 38, February 26, 2013, at 3320-21.
[107] Testimony of John Church, Transcripts, vol. 39, February 27, 2013, at 3375.

section 3 of the *Health Care Protection Act*. Giving priority to publicly funded health services by accepting money or other valuable consideration, or trying to get priority by such means, are corrupt acts. They are not only improper but also illegal in the context of that statute.

This inquiry's terms of reference in the preamble state that "it is improper to gain access to publicly funded health services through threat, influence or favour." Gaining priority through threats would also certainly qualify as a corrupt act and therefore be improper. But is it completely accurate to say that gaining priority through influence or favour are similarly corrupt and improper when, for example, the evidence as to professional courtesy revealed that some professionals extend the concept to include favours for friends and persons of influence? If a political official attempted to gain priority for himself or herself, or a friend, through the influence of their position, that would be improper. But influence and favour can also have different connotations depending on the context. My point is that this is a highly nuanced issue.

At the beginning of this chapter I wrote that preferential access implies an advantage, a priority over that which would be regarded as normal. So preferential access is a differentiation in access. That difference could be in either how quickly a service is made available – whether it is a diagnostic test, a consultation or a surgical procedure – or in the quality or extent of the service. But what makes it preferential is that the differentiation is between similarly-situated individuals.

If the faster or better access provided to an individual is based on medical necessity, then it is not a question of bestowing preference since that is the operative principle behind access to all publicly funded health services. It is only if the differential access is based on something other than medical necessity that we can call it preferential. But, as we have seen, there are varied types of preferential access.

Some types of preferential access may be ethically justifiable even if they may not satisfy the test of medical necessity, if by ethical we mean conforming to the accepted standards of society. If something is approved by legislation, it can be said that it is accepted by society. Democratic principles require us to accept that legislation duly enacted by elected legislators expresses the will of the people. If not, the people can elect others to represent them. So it can be said that any preferential access that arises as a result of legislation is ethically justified. A

similar comment might be made for accepted customs of a profession, professional courtesy perhaps, that do not violate that profession's codes of conduct and provided that those customs do not result in actual harm to others. And that becomes the ultimate test for ethical justification, that no harm be caused.

In my opinion, improper preferential access is any policy, decision or action that cannot be medically or ethically justified, resulting in someone obtaining access in priority to others similarly situated.

This definition respects the clinical judgment of physicians and accepts the function of ethical advocacy by physicians for their patients. It can include policy choices arrived at through a transparent and democratic process. The definition can encompass categories of people whose preferential access is socially accepted or tolerated. It can even include aspects of professional courtesy grounded in a defined standard of practice.

Is it necessary to include "harm" in this definition? If a decision to grant preferential access to one patient actually harms another, then it cannot be ethically justified. Here, I am referring to a deliberate act in choosing to prefer one patient knowing that another's health would be harmed – demonstrable health consequences caused by the delay in obtaining treatment.

For some act of preferential access to be improper, however, there is no need to demonstrate actual harm. First, it would be nearly impossible to prove. But second, if it is improper then harm can be assumed. Here I am speaking of harm to the health care system, to its fairness, predictability and efficiency, to the public's confidence in its integrity, and by reinforcing the improper behaviour by its example to others.

CHAPTER THREE: RESPONDING TO THE PROBLEM OF QUEUES

Earlier, I stated that this inquiry was not mandated to examine the broad policy questions surrounding wait lists for treatment and their management. But no discussion of access, preferential or otherwise, can be complete without reference to wait lists.

A. *Wait Lists*

There are numerous rationales for wait lists. A primary goal of a publicly funded health care system is to provide the necessary care to each patient according to need, and those with the greatest need should be served first. One rationale for using wait lists to allocate health care is that it is a means to regulate access to services that is based only on need, not on ability to pay or any other criteria.

But that is not the only reason why wait lists exist. They are also a result of supply and demand. When the demand for services outstrips supply, the system must find ways to effect fair access based on the need for the service. There are a limited number of specialists and facilities.

Policy-makers may use wait lists to ration health services to ensure that those services – services that are expensive – are fully utilized. In hospitals, for example, wait lists mean that operating theatres can be used at full capacity. They reduce the possibility that supply will exceed demand, which would leave excess capacity, with operating rooms empty and staff without anything to do. Wait lists, of course, may also simply be the result of ineffective management of demand coupled with insufficient supply.

Wait lists may be a useful management tool, but lengthy wait times harm patients. A lengthy wait for treatment can reduce the patient's quality of life and limit their ability to return to work; it can prolong suffering and require medical management of pain and other symptoms; it can increase stress and anxiety; it may also lead to increased morbidity and even death. Studies suggest that longer wait times may lead to worse clinical outcomes in terms of physical and social functioning.[1] Lengthy waits can also exacerbate other resource

[1] L. Siciliani, M. Borowitz and V. Moran, eds., *Waiting Time Policies in the Health Sector: What Works?*, OECD Health Policy Studies (OECD Publishing, 2013) at 27.

scarcities – for example, when patients use up hospital beds while waiting for backlogs in surgery to clear.

B. *Wait time measurement*

(i) Policy initiatives

For the general public and health system policy makers, wait times took prominence during the last decade as a major indicator of the quality of the Canadian health care system.[2]

In 2004, the federal, provincial and territorial governments committed themselves to a 10-year plan to strengthen health care.[3] Among the principal commitments was the development of evidence-based benchmarks for medically acceptable wait times, starting with cancer, heart, diagnostic imaging procedures, joint replacements and cataract surgery. These were identified as priority areas for meaningful wait time reductions. In its 2012 review of the 2004 health accord, the Standing Senate Committee on Social Affairs, Science and Technology found that wait time commitments in priority areas had "largely been met" but that the development of benchmarks was not sufficiently evidence-based or patient-centred:

> The committee also heard that the wait time agenda had certain limitations, including that the benchmarks established were not based upon sufficient research, which in some cases, led to questioning of their appropriateness by health care providers and policy makers. Moreover, they were not patient-centred in that they did not reflect the complete wait times experienced by patients across the continuum of care, with witnesses emphasising the lack of timely access to primary care physicians as being of particular concern.[4]

[2] Gregory P. Marchildon, "Canada: Health System Review," (2013) 15:1 *Health Systems in Transition* at 139.

[3] Health Canada, "First Ministers' Meeting on the Future of Health Care 2004;" http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php.

[4] Senate of Canada, Standing Senate Committee on Social Affairs, Science and Technology, *Time for Transformative Change: A Review of the 2004 Health Accord* (March 2012) at viii: http://www.parl.gc.ca/Content/SEN/Committee/411/soci/rep/rep07mar12-e.pdf; Health

The Canadian Institute for Health Information describes patient-centred care:

> To date, patient-centred care has not been well defined. The World Health Organization views patient-centered care as 'a means to improve services in relation to access, quality, user satisfaction and efficiency.' Researchers have also identified some of its key attributes. One is respect for patients' values, preferences and expressed needs; another is coordination and integration of care. As patients often wait during the transitions between care settings, better integration of health care services may reduce wait times and improve patient experiences.[5]

The Canadian Institute for Health Information recently reported progress in reducing wait times in the five priority areas, but said that much work remains to be done, both in those and other areas.[6] One concern was that identifying and concentrating on five priority areas might result in fewer resources being allocated to improve access in other areas.

(ii) Tracking wait times

One significant source of confusion in tracking wait times is the period of time they cover. In Canada, wait times are usually measured only from the point of the patient's consultation with the specialist to the time of treatment. Where there are several consultations, the clock may not start until the patient is added to the specialist's wait list for the procedure. Canada has one of the narrower measures of wait times among developed countries. For example, the Alberta Wait Times Reporting website defines a wait time as "the time between when a patient and [specialist] decide that a procedure or diagnostic test is required and the date the procedure or test is performed."[7] In contrast, England, Sweden and Finland begin calculating wait times as of the

Council of Canada, *Progress Report 2013: Health Care Renewal in Canada* (Ottawa, 2013) at 9.

[5] Canadian Institute for Health Information, *Health Care in Canada, 2012: A Focus on Wait Times* (Ottawa, 2012) at 75.

[6] Canadian Institute for Health Information, *Health Care in Canada, 2012: A Focus on Wait Times* (Ottawa, 2012) at 6.

[7] Alberta Health and Wellness (available at http://waittimes.alberta.ca).

patient's initial contact with a physician. Other countries measure the time from physician referral to a specialist to treatment.[8]

If the goal is to reduce the patient's total wait time, looking at the entirety of the patient's contact with the health care system is more appropriate. It should enable greater coordination of care throughout the patient's journey to treatment. By measuring only part of the patient's encounter with the system – wait times that occur later in the encounter – there is a risk of ignoring the equally important wait times at the front end of the system and not having an accurate picture of wait times as a whole. As one witness, Dr. Nicholas Mohtadi, put it, "We are measuring health care based on what we can measure and … ignoring what we are not measuring or what is difficult to measure."[9]

The Wait Time Alliance, a group composed of the Canadian Medical Association and 13 national medical specialty organizations, contends that several stages should be considered part of any wait time monitoring system, including finding and seeing a family physician, waiting to see a specialist and waiting for diagnostic procedures.[10] This underlines the fact that patients may encounter multiple wait times within the health care system.

Alberta is tracking, benchmarking and reporting on wait times for a number of programs and services (not just the five priority areas identified in the 2004 federal-provincial-territorial accord). A summary of these reports is published in the current Alberta Health Services (AHS) health and business plan.[11] Some of the wait times benchmarked by AHS include:

- cardiac surgery
- hip replacement surgery
- knee replacement surgery
- cataract surgery

[8] L. Siciliani, M. Borowitz and V. Moran, eds., *Waiting Time Policies in the Health Sector: What Works?*, OECD Health Policy Studies (OECD Publishing, 2013) at 35-36.
[9] Testimony of Nicholas Mohtadi, Transcripts, vol. 17, January 10, 2013, at 1319.
[10] Wait Time Alliance, *Shedding Light on Canadians' Total Wait for Care: Report Card on Wait Times in Canada* (June 2012) at 5.
[11] Alberta Health Services, *Health Plan and Business Plan: 2012-2015* (Section 3.1: "Improve Access and Reduce Wait Times").

- cancer treatment
- emergency department length-of-stay
- children's mental health
- wait in community for continuing care placement, and
- wait in acute/sub-acute care for continuing care placement.

The Alberta Wait Time Reporting System was launched on the Alberta Health website in May 2011. That reporting system shows wait time information on surgical procedures and diagnostic tests, including MRI scans and cancer services, as reported by Alberta specialists and facilities. The site allows the public to search wait times by procedure, by specialist and by facility. It also provides wait time trends over the most recent 13-month period.[12]

(iii) Demands on the system

Another important factor in this discussion is the ever-increasing demand placed on health services. More than 538,000 Canadians underwent surgical procedures in one of the five priority areas in 2012, an increase of about 21,000 over the previous year. Data from across Canada suggests that the demand for some procedures, such as joint replacements, is rising faster than the ability of health care systems to meet the demand.[13] As a result, the reductions in wait times that occurred during the first few years after the 2004 accord (which had a goal of treating 90 per cent of patients within the benchmarked times) have levelled off.

Within these national trends, however, there is evidence of medical prioritization at work. A recent pan-Canadian survey of health care system performance by the Conference Board of Canada found that wait times for non-emergency procedures have remained constant or increased in recent years. However, wait times for emergency procedures such as radiation therapy and cardiac bypass surgery remain within national benchmarks. As the Conference Board of Canada report states:

[12] Alberta, Ministry of Health and Wellness, *Health and Wellness Annual Report 2011-2012* at 21.
[13] Canadian Institute for Health Information, *Wait Times for Priority Procedures in Canada, 2013* (February 2013) at 2.

> The good news is that even as resources have become scarcer due to a growing and aging population, which increases demand for health care, wait times for procedures for the most life-threatening illnesses have not increased.[14]

(iv) Alberta benchmarks

Is Alberta meeting national wait time benchmarks? My report is not the appropriate vehicle for an in-depth analysis, but certain indicators are instructive.

Alberta is neither the best nor the worst among provinces in meeting the benchmarks set for the five priority areas.[15] For radiation therapy, 97 per cent of patients were treated within the benchmark wait times in the 2010-2012 period. This is comparable to national rates. With respect to cataract surgery, 69 per cent of Alberta patients were treated within the benchmark wait time of 112 days, compared with 83 per cent nationally. For knee replacements, 79 per cent of Alberta patients were treated within the benchmark wait time of 182 days, compared with 75 per cent nationally. Similarly, for hip replacements, 84 per cent of Alberta patients were treated within the benchmark wait time of 182 days in 2010-2012, compared with 80 per cent nationally.

AHS has adopted performance measures for treatment and discharge from emergency departments (four hours) and for treatment and admission to hospital from the emergency department (eight hours). For the fiscal year 2011-12, for the 16 busiest sites in the province, 65 per cent of treatments and discharges occurred within the four-hour benchmark and 45 per cent of treatments and admissions to hospital were within the eight-hour benchmark. The health plan proposed by Alberta Health Services is aiming at a 90 per cent compliance rate for both benchmarks by 2014-15.[16]

(v) Financing

The question frequently arises whether putting more money into the health care system will improve performance. Numerous national and international studies say "not necessarily." Alberta, with a population

[14] Conference Board of Canada, *Paving the Road to Higher Performance: Benchmarking Provincial Health Systems* (May 2013) at 39.
[15] Canadian Institute for Health Information, *Health Care in Canada, 2012: A Focus on Wait Times* (Ottawa, 2012) at 5-6.
[16] Alberta Health Services, *Health Plan and Business Plan: 2012-2015* at 27.

of approximately 3.8 million, allocated $16.6 billion for health care in its 2012-13 budget. That amounts to per capita spending of $4,606 (not the highest in Canada, that being Newfoundland and Labrador at $5,190).[17] The recent Conference Board of Canada report argues that spending more does not necessarily lead to better performance. Good performance can be achieved at various levels of spending and it is possible to achieve good health care system performance with limited resources. The report summarizes its arguments:

> Spending larger sums of money on health care does not necessarily translate into better health care performance…. It is *how* the money is spent, rather than *how much*, that will translate into better value for Canadians. And before governments make decisions on health care spending, they would do well to take stock of their own systems relative to others and adopt best practices found in Canada and in the world.[18] [Emphasis in original]

In all likelihood, long-term stability of financing would be far more conducive to good management practices and planning than short-term fluctuations.

(vi) Plans for enhanced access

AHS has acknowledged the need to improve access and reduce wait times.[19] At a minimum, AHS should consider developing a wait time measurement system that takes into account the four principal categories of waits:

1) The wait to see a primary care provider;
2) The wait for diagnostic tests and examinations;
3) The wait to see the specialist after referral by the primary care provider; and
4) The wait for treatment.

[17] Conference Board of Canada, *Paving the Road to Higher Performance: Benchmarking Provincial Health Systems* (May 2013) at 6.
[18] Conference Board of Canada, *Paving the Road to Higher Performance: Benchmarking Provincial Health Systems* (May 2013) at 54.
[19] Alberta Health Services, *Health Plan and Business Plan: 2012-2015* at 25.

There should also be a system for tracking of procedure and health outcomes. Without that, all there would be is information about process. Together this combined data would provide a much more comprehensive patient-centred picture of the true nature of waiting in the health care system.

As I have said elsewhere, the mandate of this inquiry was not to examine wait lists *per* se. However, it is impossible to overlook the fact that the very existence of wait lists and the excessive time people may wait for assessment and treatment can be important motivators for attempting to expedite access by improper means.

As previously noted, AHS has developed plans to enhance access to health services and reduce wait times. Since improper preferential access is an aspect of access generally, and enhanced access generally would tend to reduce the impetus for seeking improper preferential treatment, it is within my mandate to recommend that AHS continue with those plans, incorporating the best evidence-based practices, and that it do so transparently in consultation with all sectors of the health care system and with the public.

Ultimately, ensuring equitable access to health care within a reasonable time comes down to good planning. As noted by the Health Quality Council of Alberta in its 2012 report, "Queuing is not just a symptom of the mismatch between capacity and demand or even a 'simple' lack of sufficient capacity. Queuing is often a symptom of incomplete planning to address the variability of demand."[20]

Recommendation 4:

Reduce wait times

Alberta Health Services should continue its current efforts to improve access to health care overall and to reduce associated wait times. It should also consider implementing a comprehensive wait time measurement system.

[20] Health Quality Council of Alberta, *Review of the Quality of Care and Safety of Patients Requiring Access to Emergency Department Care and Cancer Surgery and the Role and Process of Physician Advocacy* (February 2012) at 49.

C. *Wait list management*

Wait times for medical services obviously implicate the question of access. Two other issues also directly affect access and the potential for improper preferential access. The first is how wait lists are managed (dealt with here); the second is physician referrals (dealt with in the following section).

In 1998 Health Canada reported that, with rare exceptions, wait lists were non-standardized, capriciously organized and poorly monitored. It observed that there was widespread interest in standardizing data and in coordinating and integrating wait lists.[21]

In 2002, the Romanow Commission criticized wait list management in Canada as inconsistent, uncoordinated and haphazard. It went on to recommend several steps that provincial and territorial governments should take:

- Implement procedures for managing wait lists in a centralized manner either within specific regions of a province, in the province or territory as a whole, or between provinces depending on the particular service involved;
- Implement standardized and objective criteria for assessing patients to ensure that the time they wait between when they are diagnosed and when they are treated depends only on the seriousness of their health needs. This work should be done with the full participation of health care professionals involved in providing the services;
- Provide health professionals with the necessary training to ensure that patients' needs are objectively assessed according to the standardized criteria; and
- Provide patients with a clear and understandable assessment of:
 - Why a particular service or procedure is being suggested and the options and alternatives that are available on an interim and longer term basis, including the option of seeing another physician;

[21] P. McDonald *et al*., *Waiting lists and waiting times for health care in Canada* (Health Canada, 1998).

- The relative seriousness of their needs for the particular services based on an objective assessment by health professionals and reflecting the standardized criteria;
- The approximate time they should expect to be on the wait list for a particular service given the severity of their medical need; and
- Any changes to a patient's condition or developments in the health care system that could either lengthen or shorten the wait time.[22]

To a great extent these recommendations remain as valid today as when they were first made. Wait lists generally do not have standardized criteria for deciding the priority of any given patient. There are few rules or guidelines as to when a patient should be put on a wait list. There is no standard way to account for non-medical factors such as age or family and employment circumstances when attempting to determine the appropriate patient priority on a wait list. There is no auditing of wait lists to see if those on the list are appropriately placed, whether a change in their condition requires a change in their position on, or removal from, the list, or whether they are on more than one list for the same procedure. The lack of standardized criteria for placement on wait lists for many health care services leaves people on wait lists vulnerable to queue-jumping. As the Western Canada Waiting List Project noted in a 2001 report:

> The absence of standardized criteria and methods to prioritize patients waiting for care means that patients may be placed and prioritized on waiting lists based on a range of clinical and non-clinical criteria that may vary across institutions, health regions, and provinces. This situation inevitably leads to concerns regarding unnecessary risks faced by patients who may not be getting necessary care in a timely fashion. If patients are not receiving such care on the basis of relative need and capacity to benefit, then the principle of equitable access to care is violated. It is imperative, therefore, that one of the key policy initiatives to address the issue of waiting lists

[22] Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada: Final Report* (Ottawa, 2002) at 145.

> focuses on the development of standard criteria that may be universally adopted to prioritize patients.[23]

One of the major points that came out in the evidence presented to this inquiry was that wait lists are generally managed by individual physicians or hospitals. There is little or no coordination of lists among physicians or hospitals. Specialists keep their own wait lists and generally do not merge or compare them with colleagues' lists. As a result, a patient may sit far down a long list kept by a particular specialist while other specialists may have shorter lists and could help the patient more quickly.

Specialists have wide discretion in deciding what priority a patient should have on a wait list. So do hospital operating theatre committees that decide what blocks of time to allocate to the different surgical specialities. One of the inquiry's expert witnesses, Mr. James Saunders, described them as "points of discretion":

> There are points of discretion where professional judgment of the specialist comes into play, certainly in the selection of where they place an individual in their priority list as well as in the scheduling of the operating theatres and the system and process that goes along with that. There are value judgments made there about the relative importance of the amount of time required based on work loads of both the individual physicians as well as groups of physicians by specialty.[24]

As a result, in Mr. Saunders' opinion, these two areas of decision-making, one by the specialist and the other by the hospital committee, can be prone to manipulation for reasons other than medical need.

There was evidence, however, from other witnesses that the procedures for booking operating rooms, while differing to some extent between facilities, limit any opportunity for outside interference in the operating room booking process. The common point in this evidence, however,

[23] Western Canada Waiting List Project, *From Chaos to Order: Making Sense of Waiting Lists in Canada: Final Report* (March 31, 2001) at 5.
[24] Testimony of James Saunders, Transcripts, vol. 2, December 3, 2012, at 136.

was that each surgeon submitting booking forms to a facility manages his or her own lists.[25]

Mr. Saunders also spoke about the potential benefits of a central or coordinated booking system for managing wait lists.[26] Such a system could provide better coordination of specialists' workloads through establishing standardized priorities for each type of treatment. A referral would be assessed against others on the wait list and a merged priority list would result, leading to more efficient patient flow. When a patient reaches the top of the list, the first available surgeon would be assigned to that patient. Decisions would be based on supply and demand within the system as a whole, instead of just within the narrow confines of one physician's practice. All this should reduce wait times.

Many examples exist of efforts to create central booking schemes and standardized criteria for prioritizing patients on wait lists. In Ontario, long wait lists for coronary artery bypass surgery in the 1990s led to the generation of explicit clinical criteria for prioritizing patients on wait lists, along with a centralized wait list management system. This led to reduced wait times and a more appropriate priority system.[27]

The Western Canada Waiting List Project, established in 1999, is a partnership among four western provinces, health authorities, academic health sciences centres, and medical associations to address wait list issues in five clinical areas. Its work led to practical and transparent measures for prioritizing patients waiting for service in those areas. Its research also showed that clinicians, administrators and the public were receptive to these wait list management tools.[28]

In 2007 Health Canada funded an initiative that led to the development of the Paediatric Canadian Access Targets for Surgery (P-CATS), which developed standardized priority classifications across a spectrum

[25] Testimony of Shawn Hillhouse, Transcripts, vol. 15, January 9, 2013, at 1182; testimony of Skyla Lungren, Transcripts, vol. 15, January 9, 2013, at 1213; testimony of Janice Stewart, Transcripts, vol. 15, January 9, 2013, at 1242.
[26] Testimony of James Saunders, Transcripts, vol. 2, December 3, 2012, at 112-13.
[27] D.A. Alter, A.S.H. Basinski and C.D. Naylor, "A Survey of Provider Experiences and Perceptions of Preferential Access to Cardiovascular Care in Ontario, Canada" (1998) 129 *Annals of Internal Medicine* 567.
[28] Western Canada Waiting List Project, *From Chaos to Order: Making Sense of Waiting Lists in Canada: Final Report* (March 31, 2001) at 25.

of paediatric surgical procedures.[29] P-CATS enables tracking of the wait time from the decision to refer the patient to a specialist to the initial consultation, as well as the time between the date when a decision is made to proceed with surgery and the surgery date.

New Brunswick initiated the New Brunswick Surgical Care Network based on work first done in Saskatchewan. This program, developed with the participation of clinicians, administrators and patients, created a province-wide registry for patients requiring any of 30 surgical procedures. The registry offers real-time data organized as follows: by surgical specialty; acuity of the patient's condition; expected health outcomes and benefits of surgery; clinical benchmarks identified for the procedure; type of procedure (in-patient or day surgery); and patient availability, along with a recommended date for surgery. The registry is used for scheduling surgeries, allocating operating room time and communicating with patients. The Department of Health also created an "access manager" position in each hospital to facilitate communication among patients, surgeons and the hospital.[30]

Central booking systems are also being developed in Alberta in some specialities – knee and hip replacements among them.[31] In its 2012 report, the Health Quality Council of Alberta recommended developing standardized approaches for the creation of surgical waiting lists, with priority given to surgical oncology.[32]

Several expert witnesses before the inquiry commented on standardized wait lists and centralized booking practices. Some argued that centralized list management practices alter the traditional relationship between the specialist and the referring physician, but acknowledged that they result in greater efficiency for patients. Still, such innovations

[29] J.L. Saunders & Associates Inc., *How Health Care is Delivered in Alberta* (November 29, 2012) at 14 [Exhibit 12].
[30] Report of the Taming of the Queue 2013 Conference, *Beyond the Queue: A systems approach to addressing the root causes of wait times* (March 21-22, 2013, Ottawa) at 11; see also www1.gnb.ca/0217/surgicalwaittimes.
[31] Testimony of James Saunders, Transcripts, vol. 2, December 3, 2012, at 112-13.
[32] Health Quality Council of Alberta, *Review of the Quality of Care and Safety of Patients Requiring Access to Emergency Department Care and Cancer Surgery and the Role and Process of Physician Advocacy* (February 2012) at 23.

must be addressed systematically, using evidence-based clinical guidelines, to achieve a more rational and effective use of resources.[33]

Dr. David Alter explained one drawback to centralized wait lists. Assigning individual patients a ranking number based on their clinical condition is difficult and provides an imperfect indicator of their need. The individual patient's complaint cannot be treated in isolation. "It's imperfect because we can never really account for every clinical scenario. Patients do not read textbooks, nor do their symptoms. It's imperfect because it doesn't encompass social values, and it's imperfect because it doesn't always encompass other markers of clinical severity that we know, as physicians, we respond to – cancer, dialysis, other comorbid or other ailments that we think will impact on the effectiveness of the service in question."[34] Despite seeing explicit management systems as imperfect, Dr. Alter suggested that they have been very helpful for system surveillance by bringing attention to regions or services where wait times are excessive or patient outcomes unsatisfactory.[35]

The Alberta Medical Association raised another concern about centralized wait lists in its submissions to the inquiry. It argued that centralization can limit physician autonomy and potentially interfere with a patient's continuity of care, harming the patient's health. The answer to this concern, in my opinion, is to focus on a patient's autonomy and right of choice rather than on physician autonomy. Any system of centralized management must give patients the right to choose. A patient should be permitted to stay with a specialist with whom they have a rapport or who comes highly recommended, but the patient should also be told that such a choice might entail a longer wait. And specialists must also accept that their patients have a right to choose a different specialist to reduce their wait time.

It is evident that standardizing clinical prioritization criteria and introducing consistent wait list procedures would assist physicians, hospitals and patients by better organizing various stages of health care and making them more understandable. In particular, if patients are to be served in order of need, physicians need evidence-based tools to

[33] Testimony of Lynette Reid, Transcripts, vol. 38, February 26, 2013, at 3322-24; testimony of Brian Goldman, Transcripts, vol. 38, February 26, 2013, at 3324; testimony of Owen Heisler, Transcripts, vol. 40, February 27, 2013, at 3482-83.
[34] Testimony of David Alter, Transcripts, vol. 40, February 27, 2013, at 3473-74.
[35] Testimony of David Alter, Transcripts, vol. 40, February 27, 2013, at 3476.

help them prioritize patients in their own practices and collectively prioritize patients on pooled lists. And no one in the health care system, managers or clinicians, can make knowledgeable decisions without complete, accurate and up-to-date information about wait lists and wait times.

Wait list management should therefore be part of any discussion about equitable access and the potential for improper preferential access. As stated in a 2000 article in the Canadian Medical Association Journal:

> Why should we worry about how waiting lists – especially those for elective procedures – are organized and managed? The main reason is fairness or equity. A core underpinning of publicly financed health care systems is "to each according to his or her need." Assuming that a health care intervention offers a reasonable probability of tangible benefit, those with the greatest need for the intervention should be served first, if all else is equal. The probability that tens of thousands of individual, uncoordinated decisions taken in a large, complex and diverse system will combine to yield fairness for all is vanishingly low.[36]

[36] Steven Lewis *et al*., "Ending waiting-list mismanagement: principles and practice" (2000) 162 *Canadian Medical Association Journal* 1297 at 1297.

Recommendation 5:

Develop and implement wait list management strategies

Alberta Health Services, in consultation with appropriate sectors of the health care system and the public, should develop and implement consistent and comprehensive wait list management strategies that include:

- standardized concepts and terms;
- standardized prioritization criteria, both within a given specialty and among different specialities, to better organize the allocation of shared resources (such as operating room time);
- centralized referral and booking systems;
- a system of audit and evaluation; and
- publicly accessible information on wait times, referrals and bookings, and service availability by provider (physician, clinic or hospital).

D. *Referrals*

Access to specialist physicians and procedures typically occurs through referrals from primary care physicians. Specialists then prioritize patients on a wait list based on information from the referring physician. The wait to see the specialist could be and often is longer than the subsequent wait for the actual procedure.[37]

The Standards of Practice issued by the College of Physicians & Surgeons of Alberta are meant to set out the minimum standards of professional behaviour and ethical conduct expected of physicians. One component is a standard called The Referral Consultation Process.[38] This outlines various steps that physicians are expected to follow when referring a patient to a specialist, including the requirement (except in urgent

[37] See also Wait Time Alliance, *Shedding Light on Canadians' Total Wait for Care: Report Card on Wait Times in Canada* (June 2012) at 7.
[38] College of Physicians & Surgeons of Alberta, *Standards of Practice*, Standard 6 (The Referral Consultation Process), January 1, 2010.

circumstances) to request the consultation in writing and providing all pertinent clinical information. But the practice is still not standardized.

I heard considerable testimony about the variable quality of referrals.[39] If the referring physician provides a thorough description of the clinical information available, as well as an assessment of the relative urgency of the consultation, the specialist can more accurately prioritize the patient. However, many referrals simply do not give the necessary information. Dr. Nicholas Mohtadi, an orthopedic surgeon, testified that the majority of referrals he receives do not give sufficient information for him to prioritize the referral in an evidence-based fashion.[40]

Incomplete referrals can lengthen the interval before treatment and increase frustration for the patient. Dr. Mohtadi testified that out of somewhere between 1,000 and 1,500 referrals he receives a year, he can see at most 500 patients.[41] He explained what he does when a referral lacks the necessary information:

> Q. In those sort of instances, do you follow up with that referral physician and say, "Look, I need more information" or do you get back to them with some sort of a standard as to what you are expecting?
>
> A. Sometimes, yes. And sometimes I will pick up the phone. Sometimes I will put a message on the referral and have it sent back. And, in certain circumstances, that becomes an overwhelming process, and it's actually very difficult. So frankly, it's easier for me to say I won't see the patient than to go through that process. And sometimes it would be easier just to close my practice and not accept referrals.
>
> Q. In the example I just gave, though, the quality of that referral itself could be a holdup for that patient actually getting a chance to see you.
>
> A. Absolutely.[42]

[39] Testimony of James Saunders, Transcripts, vol. 2, December 3, 2012, at 111.
[40] Testimony of Nicholas Mohtadi, Transcripts, vol. 17, January 10, 2013, at 1306-07.
[41] Testimony of Nicholas Mohtadi, Transcripts, vol. 17, January 10, 2013, at 1320.
[42] Testimony of Nicholas Mohtadi, Transcripts, vol. 17, January 10, 2013, at 1374.

A routine practice is for referring physicians to mark consultation requests as "urgent" to secure a consultation earlier. This can result in more truly needy patients being pushed down the wait list. A gastroenterologist explained why: "We regularly receive information regarding referred patients that overstates the severity of symptoms or that reports 'alarm symptoms' that are entirely absent on evaluation. Assessment of patients with less-than-urgent problems delays evaluation and treatment of patients with serious symptoms who truly require urgent care."[43]

Personal relationships (as between the referring physician and the specialist) can also affect referrals. So can the quality of advocacy of the referring physician. As I outlined previously, advocating for individual patients has long been recognized as a basic role of the physician. Physicians should try to expedite investigation or treatment for their patients when medical need requires. The point, however, is that whenever guidelines or procedures are lacking, there arises the opportunity to game the system. A lack of standardized prioritization criteria here can also motivate some to obtain improper preferential access. Ultimately, the rationale for standardizing the referral process is to have a clinically coherent and transparent method to determine who should be seen next.

There is ample evidence of the benefits of standardizing the referral process. Dr. Mohtadi described those benefits:

> [I]t's always a benefit to standardize things for the majority of patients, but the people – the proponents of standardizing the process – would say that consistency leads to better care overall; and the antagonists of that approach will say, well, there are always exceptions, and therefore, there are people that would not want to standardize.
>
> But it's absolutely clear that the majority of who we see, irrespective of our specialty or subspecialty area, are similar to the people that we saw before. So most of us have a consistent practice, and the variance within that practice is relatively small.

[43] Guido M.A. Van Rosendaal, "Queue jumping: Social justice and the doctor-patient relationship" (2006) 52 *Canadian Family Physician* 1525 at 1526.

> So standardization would improve the process of referral, and indeed, there is every intention to do that in Alberta.[44]

What Dr. Mohtadi was referring to at the end of his comment is an initiative by AHS to standardize the referral process and introduce a system of electronic referrals. Path to Care: Referral and Wait Time Measurement and Management is a multi-year project to develop provincial guidelines for each clinical specialty, specifying what information is required in a referral, defining an urgency scale, and identifying the appropriate timeline for a patient to be seen and the tests that should be done before a physician makes a referral. Central intake clinics will also be introduced in many specialty areas.[45] This is a worthwhile initiative. Efforts to further this project should continue, with physicians, program administrators and the public collaborating in all aspects of program design and implementation.

Recommendation 6:

Develop standardized referral procedures and booking systems

Alberta Health Services should continue to develop standardized referral procedures and centralized triage and booking systems to improve access and reduce referral wait times. Any such systems should be audited and evaluated, and education programs should be given to service providers about how to use new systems.

E. *Accountability*

One of the puzzling aspects of the efforts to reduce wait times across the country, and in particular efforts to set benchmarks, is the lack of real accountability for not meeting standards. There are no penalties for failing to reach a target – except of course for the patient who continues to wait with reduced quality of life. Some accountability is achieved by making information public. Data on wait times and use of services, as well as patient health outcomes, can lead to public pressure for change. It can also motivate health care administrators to improve their operations.

[44] Testimony of Nicholas Mohtadi, Transcripts, vol. 17, January 10, 2013, at 1324-25.
[45] Information available at www.departmentofmedicine.com/MAS.

The lack of penalties in Canada contrasts with the situation in several other countries. The United Kingdom, for example, introduced strong sanctions. If wait time targets were not met, administrative action resulted in budget cuts and personnel changes.[46]

A common method in many countries to reduce wait times is a wait time guarantee. Simply stated, no patient in need of care should wait more than a set period of time. If the wait is longer, the patient can choose to have the procedure done at public expense in a private hospital (in countries where there is a parallel private system) or be treated in another country (for example, for European Union countries that adopted a directive in 2011 to eliminate obstacles to patients seeking treatment in other countries).[47]

The results of such measures – sanctions and guarantees – are mixed. Countries that introduced strong sanctions on health care providers in conjunction with wait time guarantees had some success in reducing wait times. But there is also evidence that guarantees led to prioritizing patients improperly. This could happen, for example, by giving priority to patients with less urgent clinical needs to avoid them going over the wait time limit. The resources to do so might be taken from the care of patients with more pressing needs but whose wait times are not yet approaching the limit.[48] In other words, wait time guarantees could sometimes shortchange those patients in greatest need of attention.

In its 2002 report, the Romanow Commission rejected wait time guarantees. It argued that health care authorities need the flexibility to manage different procedures effectively. That flexibility could be lost with rigid time guarantees. It also expressed concern that provincial and territorial health care systems could take resources from life-saving treatments to meet the guarantees for other services, if tied to care guarantees for elective or non-life saving services.[49]

[46] L. Siciliani, M. Borowitz and V. Moran, eds., *Waiting Time Policies in the Health Sector: What Works?*, OECD Health Policy Studies (OECD Publishing, 2013) at chapter 16.
[47] L. Siciliani, M. Borowitz and V. Moran, eds., *Waiting Time Policies in the Health Sector: What Works?*, OECD Health Policy Studies (OECD Publishing, 2013) at 51-58.
[48] L. Siciliani, M. Borowitz and V. Moran, eds., *Waiting Time Policies in the Health Sector: What Works?*, OECD Health Policy Studies (OECD Publishing, 2013) at 56.
[49] Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada: Final Report* (Ottawa, 2002) at 144.

Given the limited mandate of this inquiry, it is not for me to say whether such measures would be effective. I mention them only to illustrate that, if there are to be benchmarks for wait times or guidelines for prioritizing referrals, there must also be meaningful tools to evaluate their use and effectiveness as well as to hold health care providers and governments accountable.

The impetus for gaming the system becomes greater when the system is viewed as disorganized, incoherent and arbitrary. By implementing the measures set out in the recommendations in this section, the health care system will be seen as far more comprehensible and fairly managed, reducing the incentives for queue-jumping.

CHAPTER FOUR: TRANSPARENCY AND PUBLIC ADVOCACY

A. *Transparency*

In recent years, Canadians have benefitted from far more public reporting on indicators and performance measures than in the past. This has helped hold governments accountable. The Government of Alberta and Alberta Health Services (AHS) have a wide array of information available on their websites. But there is still little engagement with the public on more fundamental issues related to the health care system, including those about access.

Transparency of the processes that drive Canadian health care, such as resource allocation and decision-making at all levels of the system, was frequently mentioned by the experts testifying before this inquiry as lacking in the current system. Prof. John Church, an expert in health policy from the University of Alberta, stated, "The work that I have done for this particular inquiry has further underlined this sense that decision-making has become very centralized and that access to basic information, both for researchers and also for the public, seems to be lacking in transparency, and just basic access to information seems to be lacking."[1] He explained that Alberta's current system has changed from being largely decentralized, with decisions made with input from the public, to a more centralized system with the creation of AHS. Prof. Church suggested that, because there are no mechanisms in place for transparency and because of the lack of information in this more centralized system, "we seem to be reeling from one crisis to another in the health care system."[2]

Echoing the call for transparency, Dr. David Alter stated, "I'm of the mind that transparency is always good, generally speaking, as long as it's managed responsibly in terms of people understanding the information that they read. So I can't see a downside of transparency because it builds in accountability."[3] Prof. Church suggested that a lack of transparency creates confusion for the public because of its lack of understanding about the health care system: "I think that that's mainly

[1] Testimony of John Church, Transcripts, vol. 40, February 27, 2013, at 3485.
[2] Testimony of John Church, Transcripts, vol. 40, February 27, 2013, at 3486-87.
[3] Testimony of David Alter, Transcripts, vol. 40, February 27, 2013, at 3488.

because nobody has sat down and been transparent about some of those complexities."[4]

Dr. Brian Goldman commented that publishing wait times for services online or making them transparent in other ways would "be helpful in the same way that we've found … that posting ER wait times, emergency department wait times, either online, smartphone, or computer at home or in the waiting room, is resulting in patients making different decisions."[5] These different decisions by patients can decrease the flow into very busy emergency rooms and lead patients to rely on family physicians or less busy hospitals. Similarly, publishing wait times for a given service could lead patients to make choices that may decrease the pressure on that particular service, for example, by choosing a different physician or clinic with a shorter wait list in order to take pressure off a busier physician or clinic.

The expert witnesses agreed that decision-making in health care needs to be more transparent for the public. Increased knowledge can help the public understand both how the system works and its limitations. Increased public education about health care options could help alleviate some recurring pressures in the system. Most important, if the public sees that the decision-making criteria in the health care system are fair, transparency can enhance public confidence in the system.

B. *Health literacy*

Transparency, however, means more than simply loading data onto a website. Many, if not most, Canadians still need help navigating what is clearly a complex health care system.

Health literacy is clearly an issue. Studies have shown that a large majority of Canadians lack sufficient health literacy – the capacity to obtain, understand and act on information about services that will help them make appropriate health decisions.[6] This deficit is even greater among immigrant populations whose first language is neither English nor French. There should be readily accessible sources of advice and even advocacy for patients who are not capable or confident enough to contact their MLA or someone in authority in the health care system, or

[4] Testimony of John Church, Transcripts, vol. 39, February 27, 2013, at 3386.
[5] Testimony of Brian Goldman, Transcripts, vol. 38, February 26, 2013, at 3325-26.
[6] Gregory P. Marchildon, "Canada: Health System Review," (2013) 15:1 *Health Systems in Transition* at 54.

who may not have a long-time personal physician with whom they can discuss their health care.

C. *Health advocacy*

Alberta Health Services has a process for receiving complaints from patients. The *Patient Concerns Resolution Process Regulation*, enacted in 2006, requires health authorities to maintain a system for processing, considering and responding to complaints. The College of Physicians & Surgeons of Alberta (College) also has a formal complaint process for issues relating to professional conduct. The College also has a form of alternative dispute resolution where staff members, called patient advocates by the College, are available to work with complainants and attempt a satisfactory resolution.[7]

These complaint processes are fine and necessary but they are still internal mechanisms controlled by AHS or the College. They do not provide the type of independent advisory or advocacy services that patients may require.

In her final submissions, counsel for the Consumers' Association of Alberta recommended that consideration be given to establishing a formal health advocate position dedicated to patient and family advocacy. She suggested modelling the role on that of the Commissioner of Health and Disabilities in New Zealand.[8] That Commissioner, established as an independent statutory position, is responsible for promoting and protecting the rights of health services consumers and facilitating the fair and efficient resolution of patients' complaints. The Commissioner is supported by a network of independent advocates who can advise and represent patients.

In 2010, the Alberta legislature passed the *Alberta Health Act*,[9] but it has not been proclaimed into force. That statute provides for the appointment of a Health Advocate who would review complaints that a person working in the health care system failed to act in a manner consistent with a Health Charter. The Health Charter would be established by the Minister of Health to guide the actions of health authorities, health providers, professional colleges and, according to the Act, Albertans.

[7] Testimony of Trevor Theman, Transcripts, vol. 29, January 18, 2013, at 2318-20.
[8] Information available at www.hdc.org.nz.
[9] S.A. 2010, c. A-19.5.

I have no information why the Act has not been proclaimed. But the position advocated by the Consumers' Association of Alberta, and as I envision it, would have much broader responsibilities than responding to lack of compliance with the dictates of an aspirational health charter.

There is merit in considering a system of independent advocates for patients in Alberta. This would likely do more to enable patients to navigate the health care system than all the data and information posted on websites. It is good to have targets and plans in place to meet those targets, but if individuals are to make informed decisions about their health care, they need someone assisting them whose only interest is their health. This advocate role would complement efforts to attain more effective wait list management and assist in achieving equitable access.

I recognize that there are two arguments that could be made against such a proposal.

The first is that it would interfere with the traditional doctor-patient relationship. After all, a patient's primary advocate, and usually the best one, should be his or her physician. But sometimes the issue at the root of a patient's complaint is the information, or lack of it, provided by his or her physician. In addition, if there is conflict in that relationship, or if the patient simply does not understand what the physician is doing or recommending, the patient needs someone independent to go to for advice and assistance.

The second argument is that a separate complaints avenue could lead to conflict with the College in its professional disciplinary role. There are two answers to this. First, if a patient's communication with the independent advocate reveals something that might be a question of professional misconduct, the advocate can turn it over to the College to investigate. Second, the independent advocate does not need to work in an adversarial relationship with the College. Indeed such advocates could work with the College's patient advocates in the resolution of concerns.

One of the questions that should be considered is who should take the lead in establishing such an office. On the one hand, since AHS is a centralized province-wide organization, it might make sense for it to become the source of advice and assistance for patients. The obvious advantage is that AHS deals with all aspects of health service. On the

other hand, the College could expand the role of its patient advocates into a more robust and independent advocate. The drawback here is that the College has no authority over, or a relationship with, all the different players in the health care system other than physicians.

Recommendation 7:

Consider creating the position of Health Advocate

The Government of Alberta, in consultation with Alberta Health Services and the College of Physicians & Surgeons of Alberta, should consider establishing an independent office of Health Advocate. The role of the Health Advocate would be to provide advice and advocacy assistance to patients and to help resolve patient complaints.

SECTION III: CASE STUDIES

The inquiry received evidence about several possible incidents of improper preferential access. Some pre-dated the creation of Alberta Health Services (AHS) in 2008, and some occurred after. I also heard evidence regarding circumstances and practices with the potential for improper preferential access. This section investigates nine specific allegations of queue-jumping or preferential access. In each instance, I determine whether the allegation is justified and, if it is, offer recommendations to address the situation.

1. *MLA advocacy*

As I discussed earlier, the allegation by Dr. Stephen Duckett of primary concern to this inquiry was of "Mr. Fix-its" or "go-to guys" in executive or administrative positions in the health care system. Among other duties, these individuals allegedly arranged improper preferential access to health care for politicians. Two individuals in particular were the subject of discussion: Mr. Brian Hlus and Ms. Lynn Redford.

In the case of both of these people, their own testimony and that of others made it clear to me that Mr. Hlus and Ms. Redford did not arrange preferential access for individuals. Rather, their duties included assisting members of the legislature and others with information about the health care system. In particular, they provided what many call "navigational advice" to help MLAs address constituent concerns.

There was no evidence proving that any MLA had used influence or other means to enhance his or her own care or that of family or friends. All current and former politicians who testified before this inquiry denied knowledge of any instances where they or any other MLA requested or demanded improper preferential or expedited care for themselves or others. However, the inquiry heard evidence about how some MLAs advocated on behalf of constituents who encountered problems in the health care system.

Witnesses who testified about this type of advocacy considered it an appropriate part of MLAs' duties. This is important and legitimate advocacy for patients, families and groups, particularly in helping people to navigate the health care system and identify changes needed to the system.

Mr. Harry Chase, an MLA representing Calgary Varsity from 2004 to 2012, described the significance of the advocacy role:

> It's extremely important. And I take it as an MLA's elected responsibility to the best of their ability, to represent their constituents in an attempt to meet their needs. There were a number of individuals who had a wide variety of health-related needs within the constituency, such as trying to find a general practitioner who would take on new patients. Trying to have the results that a family doctor would provide the Workmen's Compensation Board validated by doctors within the Workmen's Compensation Board. Trying to get coverage for certain medications has been brought up on the floor of the legislature; would the government cover them after many of the services – such as physiotherapy – were greatly restricted. Trying to get access at various points into the system so that they could begin to receive help. And of course, that has to begin with a family doctor. And if you don't have one, you are at a dead end.[1]

Mr. Chase emphasized that at no time did his role extend to arranging improper preferential access. Counsel asked, "Did you ever have one of your constituents approach you to get expedited or preferential access to health services that their situation didn't warrant?" He said, "No. The constituents had a variety of questions and a variety of concerns; whether it be home care, whether it be how could they get the services of a GP or a family physician. But no one ever asked me, 'Can you bump my position up in a line?'" Counsel then asked, "Are you then saying that you are not aware of any instances of queue-jumping occurring?" Mr. Chase responded, "I'm not aware of any existence of queue-jumping occurring not only within Calgary Varsity, limited to constituency experience, but I am not aware of any specific examples in general."[2]

However, there is a distinction between an MLA advocating for a constituent who is encountering difficulties with the health care system and an MLA interfering in a course of treatment or using his or her authority to obtain improper preferential treatment or expedited care for a family member, a friend or political supporter. The expert witnesses

[1] Testimony of Harry Chase, Transcripts, vol. 13, January 7, 2013, at 989.
[2] Testimony of Harry Chase, Transcripts, vol. 13, January 7, 2013, at 982-83.

at the inquiry considered any direct communication between an MLA and a health care provider to request special consideration to be inappropriate. Dr. Owen Heisler wrote, "There is no natural or expected relationship between an MLA and the health care provider. Such a request would suggest there would be an inappropriate *quid pro quo* implied which would be wrong."[3]

There was no evidence before the inquiry of any MLA or MLA's staff contacting a health care provider directly to advocate for a constituent or interfere with the constituent's treatment. The evidence was that calls were made – usually by staff in the MLA's constituency office – to individuals in regional health board offices (before AHS came into being) such as Mr. Brian Hlus and Ms. Lynn Redford, or to the office of the Minister of Health.

Several witnesses described the circumstances in which these contacts occurred. The Hon. Fred Horne testified that during his years as an MLA before becoming Minister of Health in 2011 he, or more likely a staff member, would often contact Mr. Hlus at Capital Health to get help for constituents. Mr. Horne said he received many calls from constituents who had questions and concerns about getting access to health care. He described two categories of calls:

> The first is what I'd call sort of navigational concerns; so people looking for information about health services that are available. Quite often looking for information about support services. So, for example, someone that's in need of – a senior that's in need of transportation that's recently discharged from the hospital, those sorts of community supports our office would maintain inventories of those services, and we would assist patients in acquiring that information. The second type of inquiry, I guess I would describe it best as a constituent calling and believing they're in urgent need of a particular health service and wanting to draw attention to their belief – the urgency of their need and their concern that it's not being met.[4]

The second category of calls would be from those placed on a wait list for a medical procedure. He would get in touch with Mr. Hlus or

[3] Exhibit 149, Expert Reports, report of Dr. Owen Heisler (January 2013) at 31.
[4] Testimony of Fred Horne, Transcripts, vol. 18, January 10, 2013, at 1505-06.

contact the Minister's office for assistance. Mr. Horne stated that these efforts never went beyond asking for information and never involved contacting a health care provider directly or asking for a constituent to be moved ahead on a wait list.[5]

Mr. Hlus testified about the service he provided as director of government affairs at Capital Health when he received calls from MLAs or their staff:

> Quite often there [were] discussions and questions, concerns that were coming up to MLAs' offices, and they would ask, for example, "An individual has been trying to get into a specialist. It's located in Edmonton, and it's been over six months and you haven't seen – and my constituent has not come in." Well, what we would do in the conversation that we would have – and it didn't matter whether or not it was somebody within Capital Health, the Capital Health region, or if it was a northern constituency, but it would come to us because the specialist was in Edmonton. Well, even though it wasn't the responsibility of Capital Health, we weren't going to sit there and say, "Sorry, it's not under our responsibility. You have to go phone someone else."
>
> Through the experience and that that we had come, quite often – or what we know is that if an individual has gone to see their GP, they're going to be referred to a specialist through their GP or general practitioner…. If an individual waiting for six months hasn't yet been able to see the specialist, we would ask them, "Has the patient gone back to the GP to get an updated medical assessment?" Because based on that assessment is how you're going to be getting in to see the specialist. If they didn't, that's what we would suggest to them.[6]

Mr. Hlus explained that he did not consider it appropriate or helpful to contact a health care provider directly: "[I] didn't even consider it because … I'm not a medical person. And just knowing how the system worked because it's a doctor-to-doctor relationship, that's where it has to occur."[7] Counsel asked Mr. Hlus, "Did any MLA constituency

[5] Testimony of Fred Horne, Transcripts, vol. 18, January 10, 2013, at 1507-08.
[6] Testimony of Brian Hlus, Transcripts, vol. 10, December 11, 2012, at 663-64.
[7] Testimony of Brian Hlus, Transcripts, vol. 10, December 11, 2012, at 665.

offices ask you to make those calls directly to service providers?" He said no. "Did your office receive any calls from MLA constituency offices identifying someone as a prominent person in connection with any inquiries about the system?" He said no. Counsel asked, "Did any MLA constituency offices contact you with inquiries on behalf of MLAs themselves or their family members?" He said no.[8]

Mr. Hlus was asked if he was ever given patient-identifying information when contacted by an MLA or an MLA's staff member. He said, "Likely no, because usually if it got to that point, if it was something specific as it related to a patient, then it would be directed to patient relations."[9] "Patient relations" was a team within the Capital Health system that would deal with individual patient health concerns.

Mr. Ron Liepert, former MLA and Minister of Health and Wellness (as the position was then called) from 2008 to 2010, described how a staff member from his department was assigned to handle issues that MLAs addressed to the Minister's office. Depending on the concern, the inquiries would be forwarded to this individual in the department or to AHS for response.

Counsel asked Mr. Liepert, "Were you ever advised of any such calls that came to your office requesting preferential or expedited care? For example, you said that you might get calls from an MLA for a constituent wanting long-term care.… Did you ever hear of any requests being made to your office by MLAs or anyone else, for example, to move that person up the wait list? Is there anything you could do to get them in faster?" He said:

> There's nothing that I recall that was ever raised with me by my staff that was felt was a concern. A typical call would probably be from an MLA that a particular constituent has been waiting a number of months for long-term care and they're just trying, on behalf of their constituent, to find out how much longer they're going to have to wait or whether there's an opportunity that there might be another facility that could accommodate them. So when I say "navigating the system," that's what I'm talking about.[10]

[8] Testimony of Brian Hlus, Transcripts, vol. 10, December 11, 2012, at 669.
[9] Testimony of Brian Hlus, Transcripts, vol. 10, December 11, 2012, at 671-72.
[10] Testimony of Ron Liepert, Transcripts, vol. 9, December 11, 2012, at 585.

There was other evidence to similar effect. Members of the legislature would contact personnel in the region or the Minister's office with a variety of constituent issues.

One incident of MLA involvement became the subject of evidence and submissions by some participants at the inquiry. Mr. David Diamond was Chief Operating Officer (COO) and Vice-President for suburban and rural communities for Capital Health from 2006 to 2008. He is now Senior Vice-President for human resources at AHS. Mr. Diamond testified that, while COO, he received a call from someone in the CEO's office and was told that an MLA had contacted that office for a constituent. The constituent was unhappy about a clinical assessment that the constituent did not need continuing care. Mr. Diamond was asked if there was anything that could be done to obtain a reassessment or verify that the assessment was accurate. The clinician was contacted (Mr. Diamond did not say whether he or someone else he directed made the contact) and the constituent was reassessed. The reassessment concluded that the constituent did indeed qualify for continuing care. Mr. Diamond said that incident was the only type of MLA patient advocacy he experienced in Capital Health but that such advocacy was "likely not uncommon within the system and not uncommon in previous jurisdictions" where he had worked.[11]

Ms. Sheila Weatherill, the CEO of Capital Health at the time, was asked about this incident. She had no prior knowledge about it, but she characterized it as an issue that was dealt with appropriately.[12]

Inquiry findings

I found no inappropriate advocacy by MLAs in the situations described in the evidence. I also find no inappropriate conduct in the incident described by Mr. Diamond. The MLA passed along a constituent's concern. That concern was communicated to the person in a position to address it (the clinician) and the matter was resolved. There was no evidence of pressure or influence to produce the end result for the constituent.

In my opinion, the type of advocacy carried out by MLAs, as described in this chapter, is an appropriate function for elected representatives. It

[11] Testimony of David Diamond, Transcripts, vol. 7, December 6, 2012, at 441-42.
[12] Testimony of Sheila Weatherill, Transcripts, vol. 14, January 7, 2013, at 1085-86 and 1134-35.

is part of their responsibility to constituents to ensure that every constituent receives the level of publicly funded service that he or she deserves – nothing more and nothing less.

2. *Courtesy calls*

The inquiry heard evidence relating to certain practices in the Capital Health and Calgary Health regions before AHS was created. These practices involved courtesy calls – or what were described as "heads-up calls" – where someone in the office of the health region CEO would call a senior administrator in a hospital facility or, if it was after hours, the responsible executive on call[13] at the time. The call would pass on information that a certain individual was in the facility, or would seek information about the status of such an individual.

Ms. Deborah Gordon, Vice-President and Chief Operating Officer at the University of Alberta Hospital in 2007 and 2008, testified about the practice. She said that her office would on occasion receive calls from the CEO of Capital Health, Sheila Weatherill, or one of Ms. Weatherill's staff members. Ms. Gordon said, "I don't remember specifics, but I do remember calls to our office saying, 'just so you're aware' – and I can't come up with a name – 'individual so-and-so is in the hospital.'"[14]

Ms. Gordon was asked if these were prominent people or family members of health executives. Ms. Gordon could only remember that they were "people who had, for whatever reason, contacted the CEO's office in Capital Health to let them know that they were in the system.… I don't believe that we were asked to do anything. It was like a heads-up notification that the individual was in our presence."[15] When pressed why the hospital would need such a heads-up, Ms. Gordon said, "I don't think it did." She said she made this point

[13] Ms. Deborah Gordon, former Vice-President and Chief Operating Officer at the University of Alberta Hospital, explained that the executive on call at the site or facility level assisted staff and physicians with any major issues that arose in the off hours when the regular supports were not all in place. The executive on call would deal with "unusual patient concerns or complaints, any crises that arose, disasters that arose, unusual clinical events that arose." At the University Hospital, executives on call were drawn from a pool of "clinical program directors and perhaps one senior operating officer and two physician leaders": Testimony of Deborah Gordon, Transcripts, vol. 7, December 6, 2012, at 458.
[14] Testimony of Deborah Gordon, Transcripts, vol. 7, December 6, 2012, at 481.
[15] Testimony of Deborah Gordon, Transcripts, vol. 7, December 6, 2012, at 482.

"numerous times" to the CEO's office, but that the office "continued to provide us the information."[16]

Ms. Gordon said that the heads-up provided by the CEO's office was passed along to the staff "just as a courtesy."[17] When asked what the staff were to do with that information, she replied, "In fact, I don't believe there was direction given to them. I think we would have been quite specific that we were not expecting them to do anything, other than to be aware."[18]

Ms. Gordon was also asked about significant or foundational donors to the hospital. She testified that on occasion she would receive a call from a foundation leader "indicating that one of their significant donors was in the facility." It was Ms. Gordon's feeling that the foundation leaders were asking staff to be aware, and that it was also "their hope that things would go smoothly" with the donor's care. Ms. Gordon testified she often took the information and "did nothing with it." She acknowledged she felt pressure "from time to time" to ensure a special level of treatment was given to the VIP but stated, "I wanted to buffer our staff and physicians from it."[19]

Ms. Brigitte McDonough served in various senior positions with Capital Health until taking on a strategic planning role with AHS in 2009. Ms. McDonough testified she would receive calls from Ms. Gordon's office that someone important was in the Capital Health system. Such calls would come only if prominent citizens were being admitted after hours. During regular hours, Ms. Gordon would go directly to the directors in the areas where the VIPs were being admitted. In Ms. McDonough's case, the calls came exclusively from Ms. Gordon, with the exception of an incident on November 30, 2007 that will be addressed in detail later. That time, the call came directly from the CEO's office.[20]

Ms. McDonough described the typical communication between Ms. McDonough and Ms. Gordon regarding VIPs in the system as follows:

[16] Testimony of Deborah Gordon, Transcripts, vol. 7, December 6, 2012, at 482.
[17] Testimony of Deborah Gordon, Transcripts, vol. 7, December 6, 2012, at 483.
[18] Testimony of Deborah Gordon, Transcripts, vol. 7, December 6, 2012, at 484.
[19] Testimony of Deborah Gordon, Transcripts, vol. 7, December 6, 2012, at 484-85.
[20] Testimony of Brigitte McDonough, Transcripts, vol. 11, December 13, 2012, at 751 and 778.

> Well, first of all, I would be called and I would be provided with the patient's name and their current location, which was most times in the Emergency Room, and I would be asked just to call down to the Emergency Room and to see how long it was going to be before they got a stretcher. … If they had already been admitted, then I would be asked to find out what unit they would be transferring to and what time … did I think they would be admitted. So I would call down, speak to the charge nurse, and get that information, and then I would call Deb back.[21]

Ms. McDonough testified that Ms. Gordon would provide, as she called it, "some context":

> She would tell me that she got a call from [CEO] Sheila's office and that Sheila [Weatherill] is in need of this information. Or she would tell me: "Do you remember Mr. So and So? He was a donor, helped us, you know, to raise funds for such and such. I've just heard he's going to be admitted. Can you just check and see how he's doing?" So it would never be for any confidential information. It would be just how he's doing, in general.[22]

These calls also asked Ms. McDonough to follow the progress of VIPs as they moved through the system, following admission to one of her units. Throughout the course of her day, and rounds, she would ask the unit manager for an update on the VIP's condition. If the unit manager did not know, she would ask them for an update by the end of the day. She would then pass along the information to Ms. Gordon.[23]

Ms. McDonough was asked about her communications with the staff on the unit following such a call from Ms. Gordon:

> Deb was transparent with me and I was transparent with the staff. So I would say: "As you know, this individual is on the unit, and I have been asked by Deb just to provide her with a bit of an update on how the patient is doing. So can you just tell me have there been any difficulties? Do they seem happy with the care that they're receiving? How are you guys doing?

[21] Testimony of Brigitte McDonough, Transcripts, vol. 11, December 13, 2012, at 752.
[22] Testimony of Brigitte McDonough, Transcripts, vol. 11, December 13, 2012, at 753.
[23] Testimony of Brigitte McDonough, Transcripts, vol. 11, December 13, 2012, at 753.

> Are they making any unnecessary demands on you?" And they would relay that information to me, and I would share it with Deb. And very honestly I can say that there never were any issues.… The staff were aware that they had a prominent person on the unit, and they treated them as they did any other patient that was on that unit.[24]

Ms. McDonough testified that, in her opinion, the staff was gracious in dealing with these requests but was still somewhat resentful since it took staff away from other work. However, staff accepted the practice because, as Ms. McDonough described it, "it was part of the culture of the organization that we worked in, that we receive these directions and that we had to follow through."[25]

Ms. McDonough emphasized that she reassured employees that they were not expected to provide better or different care for these patients. She said she was always conscious that staff was aware these calls were not about asking for one person to receive better care than another:

> What I would do with the managers is that we would have our team meetings and if there was somebody that we were keeping tabs on, then I always made sure… that they let the staff know how much we appreciate all of the good care that they give everybody. And I don't believe that anybody received better care because they were a more well-known individual than somebody who wasn't.[26]

Ms. McDonough acknowledged that these heads-up calls were infrequent. The CEO, Ms. Weatherill, apparently did not know about any concerns the staff may have had about these calls. She testified that nothing was said to her by her senior managers.[27]

Ms. Weatherill testified that most of the calls her office received were "navigational calls, advice calls." On occasion, she would make calls to advise front-line staff "for their awareness that someone would be coming in." The largest proportion of calls that came into her office were about a specific concern, something that needed to be addressed.

[24] Testimony of Brigitte McDonough, Transcripts, vol. 11, December 13, 2012, at 758.
[25] Testimony of Brigitte McDonough, Transcripts, vol. 11, December 13, 2012, at 759-60.
[26] Testimony of Brigitte McDonough, Transcripts, vol .11, December 13, 2012, at 794.
[27] Testimony of Sheila Weatherill, Transcripts, vol. 14, January 7, 2013, at 1072.

When asked why staff needed to be made aware, she explained that this was a piece of information to be factored into the general knowledge of what was happening at the facility: "There would be no expectation, no direction given, no expectation of any extra service. That's the role of physicians and clinicians to decide. And [the calls] would just simply be for awareness for them to have that additional piece of knowledge." She gave as examples individuals who had privacy or security concerns or who could be arriving at a health care facility accompanied by security people.[28]

Ms. Weatherill also said that she made "many" courtesy calls on behalf of patients who were in no way connected with people considered to be prominent or VIPs. She gave as an example a call from a northern region facility that was sending a patient to the University of Alberta Hospital. Things had not gone well for that patient. The family was quite upset and was coming in a group with the patient to the hospital. Ms. Weatherill received a call asking her to pass along this information. Such calls were "not infrequent" she said. Ms. Weatherill would usually pass such information on to the COO or the VP of medical affairs if it were "primarily a medical situation" and she would not direct staff on how to behave or what to do.[29]

Ms. Weatherill testified that there was no protocol in place for these heads-up types of calls. She described these calls as simply "a matter of courtesy … and it would have been just a simple call with no expectation of any improper extra care provided."[30]

Mr. David Diamond also testified about such a "courtesy call" when he was on an executive on call shift. He received a call from his supervisor, the Executive Operating Officer of Capital Health, Ms. Michele Lahey. She told him a board member had a family member in the emergency department. Ms. Lahey asked that a manager drop by out of courtesy to "make sure that they were doing well and just to check in with them." Mr. Diamond phoned the local site. A manager then checked in on the VIP's family, phoned Mr. Diamond back later that night and indicated all was fine.[31]

[28] Testimony of Sheila Weatherill, Transcripts, vol. 14, January 7, 2013, at 1062-63.
[29] Testimony of Sheila Weatherill, Transcripts, vol. 14, January 7, 2013, at 1120-21.
[30] Testimony of Sheila Weatherill, Transcripts, vol. 14, January 7, 2013, at 1079.
[31] Testimony of David Diamond, Transcripts, vol. 7, December 6, 2012, at 442-43.

Mr. Diamond testified that he had never been asked to do this before. He questioned why he was being asked to do so now, and was told it was a "courtesy call." Mr. Diamond did not speak with front-line staff nor did he give any direction that staff should do anything different than normal. When asked where courtesy stops, Mr. Diamond said he could not answer because he was aware of no policy or protocol about this: "It's not the kind of thing that was a very common call. In my two years in Capital Health it was the only time I was asked to do that." He said nothing changed with the creation of AHS. Things only changed when Dr. Duckett sent out the 2009 memo articulating the policy of the new organization.[32]

Ms. McDonough also testified that she noticed that the courtesy or heads-up calls stopped shortly after the creation of AHS.[33]

There was similar evidence of this practice going on, or at least attempted, in the Calgary Health Region. Ms. Janice Stewart was a senior executive in that region prior to the creation of AHS. She testified that she received a number of what she called "special requests for VIPs" who were either known to senior administration personnel or who were public figures. Ms. Stewart said these calls came from her vice-president at the time, Ms. Janet Umphrey, asking her to go and say hello to these people if they had been admitted under her care. She declined those requests because, she said, she did not think it appropriate if she did not know the person in question.[34]

Ms. Stewart believed the purpose of the calls was "to give us a heads-up that there was somebody – a public figure that had been admitted and would we make a social visit to say hello and [see] how were things going." She said it was a "fairly common practice at that time." She was direct in refusing the requests, saying she did not feel comfortable. She commented, "I didn't know those individuals personally, and I would not have visited them under any other circumstance. And I really felt that their hospitalization and whatever health concerns they were dealing with at the time, was private."[35]

Ms. Stewart had no reason to believe these calls were anything more than "a courtesy call to say: 'Hello' and 'How were things going?'"

[32] Testimony of David Diamond, Transcripts, vol. 7, December 6, 2012, at 445-48.
[33] Testimony of Brigitte McDonough, Transcripts, vol. 11, December 13, 2012 at 794-95.
[34] Testimony of Janice Stewart, Transcripts, vol. 15, January 9, 2013, at 1252.
[35] Testimony of Janice Stewart, Transcripts, vol. 15, January 9, 2013, at 1254-55.

The CEO of the Calgary Health Region at the time, Mr. Jack Davis, did not dispute or take issue with Ms. Stewart's testimony. He said, however, that he could not recall the practice.[36]

There were some other specific incidents described in the evidence but they are much more dated and really do not add to the picture provided by this evidence.

There was one incident, however, dating from 2007 that bears describing for the purpose of this chapter.

Ms. Brigitte McDonough testified about an occurrence on November 30, 2007, when she was the executive on call. She placed a call to the emergency department at the University of Alberta Hospital and asked that a VIP be moved out of the waiting room. She recounted what happened in her testimony:

> I, as exec on call, had received a call from Sheila Weatherill's office and it was either the executive assistant or the executive associate that called me. I don't recall which title she used. And she told me that there was an individual in the ER who had been in the ER for some time and that their spouse was saying that they were having a lot of pain and would I please call the ER and see if there was anything I could do.[37]

Apparently the spouse of the patient in emergency had gone to the CEO's office to complain. Ms. Weatherill did not recall the incident and, as she testified, she did not think she was in the office that day. But she said that even if she was not there, her staff would have known that the procedure was to contact the executive on call with any patient complaints.[38]

Ms. McDonough went on to relate what happened when she made the call to the emergency department. She asked the nurse in charge if she anticipated "this individual was going to be able to get in soon to be seen?" The nurse responded that it "didn't look likely." Most of the stretchers in ER were already full of patients waiting to be admitted. The nurse did not know how the patient was doing and directed the

[36] Testimony of Jack Davis, Transcripts, vol. 21, January 14, 2013, at 1681-83.
[37] Testimony of Brigitte McDonough, Transcripts, vol. 11, December 13, 2012, at 778-79.
[38] Testimony of Sheila Weatherill, Transcripts, vol. 14, January 7, 2013, at 1093-95.

inquiry to the triage nurse. The triage nurse refused to go see the patient. Ms. McDonough testified:

> She became quite defensive and she told me that the waiting room was full of patients and that she didn't have time to go and see every patient and that what they do is they'll check on patients every 15 minutes or so and she would have done her last check just shortly before that. I said, "Well, I really appreciate that and I know how busy you are, however, I received this call from Sheila's office and this individual's spouse is really concerned about the amount of pain that he's in and I need you to please go and check that patient." And she said, you know, she made a comment that, you know, she didn't care if the request came from Sheila's office or not, that she was too busy.
>
> So I said, "Are you refusing to see this patient?" And she said, 'Are you telling me I have to?' And I said: "Yes, I'm directing you to please go and see this patient. And if this patient is in any pain, then could you please have one of the Emergency Room physicians come out and take a look at them to see if their pain is manageable or not."[39]

The nurse agreed to do so and hung up. Ms. McDonough testified it was within the scope of her authority to give those directions to the nurse who resisted taking them. Ms. McDonough said she was aware that the emergency room was busy, but also admitted that she did not know the medical condition of the other patients waiting, or where they scored in the CTAS priority.

The triage nurse on duty that day, Ms. Lori Jobson, did not testify in person but provided an affidavit. In it, she stated:

> I explained to Ms. McDonough that there had been people waiting all day, some since 9 a.m., and stating something to the effect of "Should my no-fixed address guy from 9 a.m. wait longer because he doesn't know Sheila Weatherill?" … I advised Ms. McDonough that I had just re-assessed the patient. She asked if a doctor could look at the person. I did

[39] Testimony of Brigitte McDonough, Transcripts, vol. 11, December 13, 2012, at 780-82.

> not need her to tell me to reassess a patient, as that is part of our normal practice.[40]

The patient was reassessed and it was determined that the patient was stable and able to wait until appropriate space became available.

This incident was made the subject of a complaint by Dr. Brian Holroyd, the Chief of Emergency Medicine at the time, and Dr. Paul Parks, an emergency physician. The complaint was made to the Chief Operating Officer. The doctors were particularly concerned about the overwhelming pressures confronting the emergency department at the time. Dr. Holroyd felt that the executive on call should have tried to help address the inability of the emergency department to meet patient demands, not pressure the triage nurse to expedite one patient's care.[41]

When asked about Ms. McDonough's conduct with respect to requesting or directing expedited care for this patient, the Chief Operating Officer, Ms. Gordon, stated this would not be something that would have been supported then or now.[42] However, there was no discussion about the possibility of expedited care for a VIP. Indeed, the evidence is far from clear that the patient in question was a VIP of any sort, that being an assumption made by one or more of the participants in this incident.

Inquiry findings

What can I conclude from this evidence? First, all of the examples are drawn from the period before the creation of AHS and the distribution of the Duckett memo of June 11, 2009. This says to me that this practice is no longer as widespread or common as it once was. I use the terms "widespread" and "common" carefully, not in the sense that these calls were frequent but that it was an accepted practice.

The other important point to draw from this evidence is that it does not reveal any actual incidents of improper preferential access. In no case was there evidence that the VIP who was the subject of one of these courtesy calls actually received expedited or preferential care. That says to me that the front-line staff made an effort to treat all patients with the same degree of care.

[40] Exhibit 68.
[41] Testimony of Brian Holroyd, Transcripts, vol. 6, December 5, 2012, at 411-12.
[42] Testimony of Deborah Gordon, Transcripts, vol. 7, December 6, 2012, at 466.

This is not to say that there are no potential problems with this practice. The key one was illustrated by the evidence of Mr. Gordon Self, Vice-President of Covenant Health responsible for mission, ethics and spirituality. Covenant Health is the Roman Catholic-based organization that provides hospital and other care under contract and financing arrangements with AHS.

Mr. Self was involved in drafting a policy in 2007 on accommodating special requests. The policy was prompted by calls from the CEO of Capital Health to the CEO of Covenant Health (or Caritas, as it was then known) and these calls were sufficiently frequent that it was felt that a policy was necessary. Mr. Self testified:

> What we had noticed, there was a number of times where one of the issues that we brought forward as a senior team for debrief was related to on call and receiving a phone call or some other – like another inquiry, either in person or through the paging – related to accommodating a special request.[43]

The nature of such calls was to give Caritas's executive on call a heads-up that a VIP, perhaps a board member or some other person of significance in the community, was in one of the facilities. Mr. Self testified he personally received such calls. He remembers being on call at Providence Renewal Centre one evening when he received a heads-up sort of call. He did not remember who the VIP was or what made that person prominent, but said it was an example of a call he would have reported to the executive team. He testified the calls never went beyond making the team aware that a VIP was in the facility.[44]

Still, it was unclear what such information was meant to achieve, which is the primary reason Caritas wanted to develop a formal policy. A policy would, in Mr. Self's words:

> … acknowledge that there's a power imbalance when a funder is asking the funding – the agency that's been funded by the funder to – letting us know that there's a heads-up, giving us a heads-up about a person being in our facility. We weren't quite sure what to do with that. We certainly couldn't ignore

[43] Testimony of Gordon Self, Transcripts, vol. 11, December 13, 2012, at 705.
[44] Testimony of Gordon Self, Transcripts, vol. 11, December 13, 2012, at 706-07.

> it. And that's what led us to kind of try to develop some sort of clarity about what our response will be to this.…[45]

Mr. Self emphasized the need for clarity and consistency:

> These are our staff. These are physicians appointed to work within our facilities. And so we did not want to leave our physicians and staff alone to try to figure it out on their own. And whenever you don't – in the absence of clear policy, you always run the risk of having varied practice. So we wanted to have a uniform, singular sort of approach.[46]

Mr. Self testified that he did not know of any calls that explicitly requested preferential or expedited treatment. Yet, there was still ambivalence felt about these calls. Mr. Self explained:

> There is a power imbalance.… But just given the significance of the funding, our dependence on the funding, we were kind of left wondering, is there more to the request? It was unclear if we were to – if we were to not go to great lengths to make sure that this person was whatever, had some additional care, would there be a consequence? I think that would be a question that I had. I can't speak for my colleagues, but you kind of wonder if it is a benign request, heads-up, or just a courtesy call, or are there other expectations that go with that?[47]

This highlights the concern about these types of courtesy calls. What is the recipient of the call to think? Is the purpose of the call merely a heads-up or is there an implicit expectation that something more than the usual level of care and supervision is required? The absence of a clearly defined protocol on how front-line staff are to respond may lead to such calls being misinterpreted. As one expert witness, Dr. Lynette Reid, wrote, "It would be irresponsible to make such a call without a defined and stated goal; front-line staff would reasonably conclude they are being asked to deliver special treatment."[48]

[45] Testimony of Gordon Self, Transcripts, vol. 11, December 13, 2012, at 708.
[46] Testimony of Gordon Self, Transcripts, vol. 11, December 13, 2012, at 711.
[47] Testimony of Gordon Self, Transcripts, vol. 11, December 13, 2012, at 737-38.
[48] Exhibit 149, Expert Reports, report of Dr. Lynette Reid (February 15, 2013) at 32.

It is important to draw two distinctions in this discussion. First, there is nothing inappropriate about senior administrative officials asking front-line staff about the status of a patient when it is truly a patient concern – in other words, a response to a complaint about the treatment of any patient. I distinguish between calls regarding patient concerns and mere informational or heads-up calls that someone in particular is in the system.

It would obviously be much better to have complaints and calls about patient concerns directed to a central point – such as the office of the Patient Concerns Officer established by AHS. Such complaints and calls could then be tracked and systematically documented.

Second, one must also distinguish between mere informational calls and those whose purpose is to alert front-line workers, for a legitimate reason, of the need for special measures. A high-profile patient may cause disruption to the care of others. There may be intense media interest or security issues associated with the presence of such an individual. In these cases, it is appropriate and even necessary to notify front-line staff of the person's presence. As another of our expert witnesses, Dr. Owen Heisler, wrote: "VIPs bring an interest and entourage that impede not only their care but [that] of others in the same ward.… [F]ront line staff's being aware is very reasonable so they can appropriately respond to events or comments in this context."[49]

The Covenant Health policy on accommodating special requests speaks to the need to take special steps in some circumstances. It states that, "[g]iven the public status or profile of certain individuals, it may be ethical to assign the person a private room to mitigate breaches of confidentiality and to protect their dignity and privacy." This, however, is preceded by the general admonition that "it is *unethical and wrong* to allocate resources to an individual of influence or celebrity status when someone else may be disadvantaged or harmed."[50]

There is a distinction therefore between calls that merely inform front-line staff that someone important is in the system and those that alert staff to the need to consider special arrangements. With calls about special arrangements, physicians and clinical professionals are usually

[49] Exhibit 149, Expert Reports, report of Dr. Owen Heisler (January 2013) at 31.
[50] Exhibit 48 [emphasis in original].

best able to determine what measures to take and how those measures may affect clinical operations or the well-being of other patients. Physicians and clinical professionals should be the ones to decide what, if anything, to do in response to a call.

In closing submissions for AHS, counsel submitted that I should consider a recommendation to the effect that AHS staff and professionals working in the public health care system be educated on how "to avoid actions and behaviours that might inadvertently be interpreted … as an expectation to offer or provide improper preferential access, including routine 'notification' about 'persons who may attract public or media attention' receiving care within the health care system."[51] AHS should develop a policy that clearly defines the circumstances under which such notification or courtesy calls should be made, to whom they can be made, and how those receiving such calls should respond to them. Such a policy should distinguish between calls relaying patient concerns and those alerting staff to the presence of high-profile patients.

Recommendation 8:

Develop a policy on courtesy calls

Alberta Health Services, in consultation with other sectors of the public health care system, should develop a policy on information or courtesy calls that clearly defines the circumstances under which such calls should be made, to whom they can be made, and how those receiving such calls should respond to them.

3. *The Paula Findlay case*

Paula Findlay, the daughter of Dr. Max Findlay, a neurosurgeon who practises at the University Hospital in Edmonton, was in Edmonton in July 2011 for a World Cup triathlon race. The race was to be held on July 10. On July 7, Ms. Findlay had a medical problem that saw her end up at the University Hospital for magnetic resonance imaging (MRI) later that day. Dr. Findlay became actively involved in arranging for the MRI and in fact wrote the requisition for his daughter to have the MRI. This gave rise to two concerns – whether he had acted

[51] Closing Submissions of Alberta Health Services, April 1, 2013, at 24 (Exhibit 164).

improperly in treating a member of his own family and whether his actions led to improper preferential access to the MRI for his daughter.

Dr. Findlay explained how the events unfolded:

> I was in my clinic that morning and received a phone call from [Paula Findlay's] coach … informing me that she had had a problem. And it was one that I wasn't fully aware of and that it was getting worse; and he was suspicious that she might have an important injury, and that he thought it should be looked at.[52]

Dr. Findlay told the inquiry that high on the list of possible injuries was either a stress fracture or avascular necrosis. At the time, Paula Findlay's main team doctor was in Victoria and was not available. The coach had also not been able to reach her sports/family doctor in Edmonton.

Dr. Findlay told the coach that he would "look into it":

> [F]irst of all, I phoned Paula to find out if … she was OK with all of this, and I really wasn't aware that she was having just that amount of pain. But she told me she, that day, was almost unable to walk, it hurt so much. And so with that information, I went down to the radiology department to talk this over with one of my colleagues because I wasn't sure which investigation would be the best. I know that it's either a nuclear bone scan or a magnetic resonance image. So I wanted to get his opinion.[53]

Dr. Findlay was accustomed to working with MRIs. He would write requisitions for MRIs in his practice every working day. He explained the process:

> MRI requisitions go in different ways. If it's a routine follow-up or an entirely non-urgent MRI, it would go in through hospital mail or electronically; but if it's a more urgent

[52] Testimony of Max Findlay, Transcripts, vol. 19, January 11, 2013, at 1532.
[53] Testimony of Max Findlay, Transcripts, vol. 19, January 11, 2013, at 1534-35.

> situation, I hand deliver the MRI requisition down to the MRI area after talking to the radiologist.[54]

He would speak to radiologists directly by going down to the MRI facility, where they have a reporting station. The urgency of an MRI is a joint decision between him and whichever physician or whoever else has referred the patient to him. He would also take the requisition and discuss the patient's condition with the radiologist.[55]

In the case of his daughter, Dr. Findlay spoke with a radiologist by the name of Dr. Naik:

> I just explained the situation and the concern we had and the type of injury we were looking for, and what did he think was the best test. And it was a magnetic resonance image, yes. And then we talked about that.[56]

Dr. Naik asked Dr. Findlay to get a requisition into the radiology department and to have his daughter come to the hospital.[57]

Dr. Findlay did not send his daughter to the emergency room because, "We don't send patients to the emergency room if they don't have an emergency that requires emergency room assessment … or [are] in need of an emergentologist, and she didn't."[58] Dr. William Anderson, a radiologist who later investigated the incident for AHS, was asked whether it was necessary for Paula Findlay to go to the emergency room:

> No … absolutely not. There's … nothing that people in an emergency room can do for her. This is not an emergency room issue. That is, does she need surgery or not? And so, she needs a diagnosis. And the diagnosis is simple. She has a stress fracture or an AVN [avascular necrosis] of the hip or she doesn't.[59]

[54] Testimony of Max Findlay, Transcripts, vol. 19, January 11, 2013, at 1528-29.
[55] Testimony of Max Findlay, Transcripts, vol. 19, January 11, 2013, at 1529.
[56] Testimony of Max Findlay, Transcripts, vol. 19, January 11, 2013, at 1535-36.
[57] Testimony of Max Findlay, Transcripts, vol. 19, January 11, 2013, at 1537.
[58] Testimony of Max Findlay, Transcripts, vol. 19, January 11, 2013, at 1539.
[59] Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1412.

Commission counsel asked Dr. Findlay if there was any discussion with Dr. Naik about the urgency of this MRI request. He said there was:

> And I think he agreed it should be done urgently that day because I thought it should be done, well, either that day or the next day, just from my father's point of view, but he felt that it could be done, should be done that day.[60]

Dr. Findlay did not speak with any other doctor before arranging the MRI:

> The bottom line was that she needed imaging of the joint to find out what the injury was, which would have been more important than a physical examination at that point. It hurt.[61]

Dr. Anderson also confirmed to this inquiry the importance of an MRI in this case. He had heard about the Findlay MRI because a media relations officer at AHS had asked him to look into the case "to see whether Paula Findlay had, quote unquote, jumped the queue…."[62] Dr. Anderson knew that Paula Findlay was a world-class triathlete and was the daughter of Dr. Findlay.[63]

Dr. Anderson contacted Dr. Naik for details about the incident:

> And I said, "So what's the story?" And he said, "Well, it's Max's daughter, and Max came and talked to me and said … someone thought she either had a stress fracture or an avascular necrosis of the hip." And so I thought we should do it.
>
> He's a neuroradiologist like me … and it seemed perfectly reasonable to me, if that's what they were worried about, that they should have it. But I wanted to be sure … about that.[64]

Commission counsel asked whether a stress fracture or an avascular necrosis of the hip would be highly significant in a high-functioning

[60] Testimony of Max Findlay, Transcripts, vol. 19, January 11, 2013, at 1536.
[61] Testimony of Max Findlay, Transcripts, vol. 19, January 11, 2013, at 1534.
[62] Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1405.
[63] Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1402-03.
[64] Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1408.

athlete. Dr. Anderson answered that it would depend on where the problem was:

> In the hip, it's very important because it's weight bearing and it's a significant bone. And if it does fracture, a stress fracture can go on to a fracture. So if it does fracture, it means major surgery and complications thereof, and a whole bunch of other things, including, perhaps, a slightly shorter leg and [the] long-term outcome is not very good.[65]

Dr. Anderson also said that the presence of a stress fracture in an athlete was more significant than in an ordinary person:

> So in fairness to Paula, she has a couple of things that most of us don't have. One, she's pretty talented. But two, she is also in a sport that is repetitive and jarring…. And those elite athletes are different again than, for instance, me. And that is that, if I have pain, I typically quit. Elite athletes are trained to run through or train through their pain. That's part of the deal of being an elite athlete. You don't get there if you can't do that. So their mentality would drive them to push harder than the average person would so that chances of her completing a fracture if it was a fracture would be much higher than me….[66]

Commission counsel asked Dr. Anderson if it was appropriate to compare Paula Findlay's case to anybody who has a possible diagnosis of a stress fracture. Dr. Anderson replied, "Absolutely not." A fracture of the foot, for example, was not nearly as grave as a fracture of the hip. He continued that a hip fracture would be serious in his 13-year-old daughter, who is heavily involved in dance:

> She dances 20 hours a week. And if she had a similar sort of question coming from her physician, then … I would say that it's time to get her in for an MRI. And I would say we should be doing it urgently.[67]

Commission counsel asked what Dr. Anderson would do in the case of a non-competitive dancer with the same possible diagnosis of hip fracture:

[65] Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1408-09.
[66] Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1409.
[67] Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1425-26.

> A similar young lady … who is not a dancer would not fit into the same category. And it's because she is not going to go and potentially fracture that hip. So there is a big difference.
>
> And I think that's where the physicians have to talk to each other, and that's why we say you must phone me to get this done within an urgent category … you know, right away.[68]

Counsel for the Consumers' Association of Alberta asked the following question:

> I understand some criteria were applied to Paula's case and the clinical assessment coming from the requisition and perhaps a telephone call or an in-person discussion with Dr. Naik, and the consideration of what she does were the deciding factors.
>
> Who has prioritized high-functioning athletes as being more important than the farmer who is injured in his work and has the same injury and needs to work to support his family?

Dr. Anderson replied:

> [W]ith respect to the farmer, we would have to understand what that farmer does in his work. So if the farmer happens to be driving his tractor around, which is equivalent to me sitting and doing my work, then he would fall into that category of being an elective urgent, the OP1 category, like I would. If … the physician knows that farmer … and gives us some reason why it needs to be done sooner, we will do it sooner if we can. We will get it in.
>
> So it's the individual in their life and what are the factors that come [into] play that drive our decision, and we generally are a bit of a wall because we have limited resources. We tend to put up barriers rather than take them down. But if that farmer is doing something that potentially would injure – maybe it's hay baling season. I don't know, I think they pick them up in machines now, but when they lift them, maybe – and it's the one where they were turning that particular – I don't know. But if the physician had that discussion with the patient and

[68] Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1427.

> phoned and gave a case to us as to the urgency, it becomes that urgency.
>
> So it's not the fact that you are an elite athlete. The other factors are in there. What is she doing that's different? What is her mindset that is different? What is driving that person to complete the fracture rather than staying off it?
>
> So if you are telling me that the farmer – it's the end of the season, he's got crops that have to come off, and he's got to do these things and that was the story, we would try and do something to get him in sooner. We would try.[69]

Commission counsel pointed out that the decision to give Paula Findlay an immediate MRI was made "without documentation from the trainer in any form … of his assessment or ability to assess … and without documentation on the requisition of why this is important for this person." Dr. Anderson said:

> We do that every day. That's a daily occurrence. I do not have time in my day to write everything down, to keep track of the discussions I have on the phone or person to person. I'm lucky, or our system is lucky enough if we can get the patient name, where they are and what their UNI number or unique identifier in these discussions [is]. So the fact that we don't have documentation to me is irrelevant. The fact that there is … a face-to-face discussion between Dr. Naik and Dr. Findlay. And that occurred.[70]

Dr. Findlay testified that he discussed with Dr. Naik the possibility of sending Paula Findlay outside the public system. Dr. Findlay said, "That was something … that I was quite willing to undertake." However, his colleague thought the MRI would be better done at the University Hospital "because the sub-specialist in musculoskeletal magnetic resonance imaging was actually working at the University Hospital that day. And he also felt confident that the schedule was such that they would be able to slide in an extra patient later in the day."[71]

[69] Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1439-40.
[70] Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1442-43.
[71] Testimony of Max Findlay, Transcripts, vol. 19, January 11, 2013, at 1536.

In contrast, Dr. Anderson argued that the better course of action would have been to go to the private sector for the MRI:

> [A] lead athlete such as Paula, being world class, and being in a competition coming up, you don't want anybody to know that she potentially has an injury if she was going to compete. I would have told him, "Go have it done privately," and it's done, doesn't affect anybody. Nobody knows about [it] and, more importantly, you wouldn't see her in a hospital walking in getting registered, you know, walking down the hallway. People may recognize her. "Oh, here is Paula Findlay."
>
> You know, from a competitor's perspective, if anybody knows that she's got an injury, there's an advantage to them.
>
> So, you know, sheer fact it was in the paper is a disadvantage to Paula Findlay for sure, but I would have highly recommended to Max, "Go to the private system."[72]

Dr. Findlay testified about the time involved in securing his daughter's MRI:

> If memory serves, I'm sure it was in the early afternoon [that his daughter arrived at the hospital]. I know that she was there for hours and hours. So again, from the timeline that … was forwarded to me from, I guess, from yourself … her MRI scan was done late in the afternoon, and she was there for hours before that."[73]

He himself did not decide when his daughter's MRI would occur. He did not know who made that decision.

Counsel asked Dr. Findlay if he was concerned about anyone being bumped to make way for his daughter. He was not, he said:

> Well, because the way the scheduling works with the MRI is that there are opportunities to get emergency or urgent cases done between normally scheduled patients.[74]

[72] Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1415-16.
[73] Testimony of Max Findlay, Transcripts, vol. 19, January 11, 2013, at 1540.
[74] Testimony of Max Findlay, Transcripts, vol. 19, January 11, 2013, at 1542-43.

Counsel asked Dr. Anderson who makes the decision about when in the day an emergency patient such as Paula Findlay is seen. He replied that it was the triage radiologist, in this case Dr. Naik. Openings during the day could result from patients not showing up or cancelling their MRI appointments. Counsel pointed out that Paula Findlay's requisition for an MRI was sent from Dr. Findlay's office at 11:39 a.m. The MRI was completed at 5:09 p.m., about 5 ½ hours later. Dr. Anderson said this was a normal wait in such cases:

> That would be typical for what would happen for one of these urgent outpatients. We tell them to get there as soon as you can, bring a book, and we will put you in whenever we can put you in. And so 5:00 would have been a reasonable time.[75]

Dr. Anderson said it appeared Paula Findlay waited about an hour and a half from the time of her arrival at the hospital to when the procedure began. That waiting time was not unusual for an urgent case "at that time of day." The radiology clinic, he said, was busiest in the morning while it dealt with inpatients and emergency patients. By early afternoon, the clinic tends to have caught up with its patient load.[76] Counsel asked if seeing Paula Findlay in the urgent slot would have put extra pressure on staff. Dr. Anderson said he did not believe this had happened. There was less pressure in the summer and, in any case, he understood that "… it wasn't an overly busy day that day, that they could squeeze her in."[77] Asked if he thought this was a case of queue-jumping, Dr. Anderson said no. Asked why he thought so, he said, "I think it's appropriate care for an individual who had a potential problem."[78]

Dr. Anderson also provided some background information about triaging for MRIs. He described the categories assigned to patients that determine, in principle, how quickly they need to receive diagnostic imaging. OP1 means the patient should be seen within one week; OP2 within a month; and OP3 within two or three months (two months for CT scans and three months for MRIs).[79] Dr. Anderson said that 90 per cent of patients in the OP1 category – who should be seen within a week – were seen within five weeks in Edmonton, and within 12 weeks

[75] Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1418-19.
[76] Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1421.
[77] Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1422.
[78] Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1422-23.
[79] Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1389.

in Calgary.[80] Ninety per cent of OP2 patients – who should be seen within a month – were seen within 19 weeks in both Edmonton and Calgary. The corresponding figure for OP3 patients who need MRIs – who should be seen within three months – was 30 weeks in Edmonton and 39 weeks in Calgary.[81]

Dr. Anderson explained that, with certain urgent cases, communication between referring physicians and radiologists cannot be done on paper because it might take too long; in such cases, physicians communicate directly with radiologists. He said, "Anything that must be done … really urgently, like within 48, 72 hours, should require a phone call."[82] Or, where clinics are located in hospitals, physicians often speak to radiologists directly: "[The physicians] will oftentimes wander down and talk to [the radiologist]."[83]

Counsel asked Dr. Anderson what proportion of patients seen in the radiology department in a typical day needed urgent service. He said roughly 20 per cent.[84] Dr. Anderson said that it virtually never happened that someone among the 80 per cent of less urgent patients was bumped to accommodate an urgent patient:

> Even if it's a pretty routine sort of thing, they're looked at as being urgent patients to get them done as fast as we can. They have waited their time. So we do not bump them. And if we do, we may reschedule, but we would never bump them to do an inpatient. They may wait in our facility. They may wait for an hour or two hours or, unfortunately, maybe a little bit longer, depending on what's happening in emergency, but they will be done that day.[85]

The College of Physicians & Surgeons of Alberta investigated the Paula Findlay MRI incident. Dr. Findlay stated, "They reminded me that it was against our code of ethics to treat members of our own family unless it's an emergency and there is no other physician

[80] Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1390-91.
[81] Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1391-92.
[82] Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1389-90.
[83] Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1398.
[84] Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1400.
[85] Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1402.

available." He said that he "certainly acknowledged that that … was contrary to our code," and apologized.[86]

Dr. Trevor Theman, the registrar of the College, said that a news article had led the complaints director to initiate the investigation.[87] Dr. Theman was referred to a letter of apology of August 3, 2011, signed by Dr. Findlay and directed to the College's resolution advisor. Counsel asked how this letter came about. Dr. Theman said, "I believe it was at the request of [the resolution advisor]." The College's complaints director considered the apology contained in Dr. Findlay's letter sufficient to resolve the matter.[88]

Inquiry findings

This incident raises two significant questions. One is the ethical question as to the propriety of Dr. Findlay inserting himself into his daughter's care. There are standards of practice prohibiting such conduct except in certain circumstances. That issue was addressed by the College and is not within my mandate.

The second question is, however, within my mandate. Does this incident reveal a case of improper preferential access? Commission counsel submitted that, even if we accept that it was medically urgent to conduct an MRI, there remains the question about whether the average Albertan with the same injury, but not a recognizable high-profile athlete and with no family connections, would receive the same care.

It might be possible to look at this incident through the lens of professional courtesy. There is no doubt that Dr. Findlay facilitated the service received by his daughter. But the evidence demonstrates that Dr. Findlay did what he normally does with any other patient – speak directly with a radiologist. In the Findlay case, the radiologist had times set aside for urgent cases and Ms. Findlay was seen during one of those times. No professional courtesy was involved.

The evidence also demonstrates that usual procedures were followed. The radiologist, after a discussion with Dr. Findlay, concluded that an urgent MRI was warranted. The assessment was based on the overall

[86] Testimony of Max Findlay, Transcripts, vol. 19, January 11, 2013, at 1544.
[87] Testimony of Trevor Theman, Transcripts, vol. 29, January 18, 2013, at 2322.
[88] Testimony of Trevor Theman, Transcripts, vol. 29, January 18, 2013, at 2323-24.

clinical presentation. Earlier in this report, I said that physicians must be able to take into account all sorts of factors to enable good clinical judgment. Some of those factors do not involve acuity. In this case, the other factors were that a patient such as Paula Findlay was accustomed to putting repeated stress on her joints, accustomed to working through the pain, and thus more likely to cause even more severe damage in the absence of a timely diagnosis and treatment, if treatment was necessary. As Dr. Findlay's counsel stated in his submissions, "The evidence was that the fact that she was a world-class triathlete was relevant, not because of any 'status' it conferred, but as part of her clinical picture…."[89]

Ms. Findlay clearly received preferential access over others in one sense, since she had a much shorter wait for an MRI than most people. However, that preference was based on clinical considerations – the potential of a worsened injury if it was not diagnosed and treated promptly. That placed her in a more urgent category of patients than many other patients. The preference was therefore proper.

We can conclude that she received improper preferential access only if we decide that elite athletes are not entitled to have that one factor – the prospect of an injury worsening if not diagnosed and treated promptly – taken into account in their placement on a wait list. Society must make this judgment. That is not the role of this inquiry. We, as Canadians, take pride in the achievements of our athletes on the world stage. We support the expenditure of public funds to sponsor and support many of them. But whether we, as a society, accept such athletes receiving preferential access to publicly funded health services has yet to be determined.

4. *The Calgary Flames and the H1N1 vaccine*

In 2009, AHS and every health organization on the continent faced a need to respond to the H1N1 pandemic. This was a major challenge in Alberta as elsewhere. Mass immunizations against the virus began at public clinics in October 2009. Lineups were long and sometimes chaotic. At the end of the first week, AHS closed the clinics temporarily due to a shortage of vaccine. A controversy then erupted over news reports that Calgary Flames hockey players and their

[89] Closing Submission re Dr. Max Findlay, March 28, 2013, at 3 (Exhibit 168).

families had been immunized at a private facility, avoiding the lineups at the four public vaccination locations in Calgary.

The Calgary Flames' team doctor, Dr. James Thorne, and several nurses involved in the Flames' vaccinations described the incident to the inquiry.

Dr. Thorne started working as a physician with the Calgary Flames during the 2002-03 hockey season. He rents a clinic, the LifeMark clinic, located in the Father David Bauer Arena. Dr. Thorne stated that, in the summer of 2009, the National Hockey League was planning to respond to the H1N1 epidemic, fearing that games and cross-border travel would have to be cancelled. The players were not medically high-risk since they did not, for example, have cancer or compromised immune systems, but they were high-risk in one sense because they had frequent contact with the public through handshaking, signing autographs and moving through crowds. As well, the team environment – being in a locker room together or travelling by plane together – put the whole team at risk.[90]

Dr. Thorne was also concerned because on the Saturday before the Monday (October 26) when the clinics opened, the Flames had played the Edmonton Oilers, and two Edmonton players were playing with an influenza-like illness. One Flames player also had an influenza-like illness. Because of this, he saw some urgency in getting the vaccine. However, it was quickly apparent that lineups were long at the four public clinics. The long lineups made him think that it would "probably be a bad idea if the Calgary Flames showed up unannounced to one of these lineups." He thought some preparation was needed.[91]

Ms. Debbie Hyman, the clinic manager in October 2009 at one of the public clinics, the Brentwood clinic, confirmed the challenges facing public clinics. The clinics functioned on a first-come, first-served basis. She described the H1N1 vaccination process as chaotic. She said there were long waits and the waiting crowd was very angry and very impatient. At times, she felt that staff members were being threatened. She even called Calgary Police for support at one point because she did

[90] Testimony of James Thorne, Transcripts, vol. 19, January 11, 2013, at 1564-65.
[91] Testimony of James Thorne, Transcripts, vol. 19, January 11, 2013, at 1567-68.

not feel safe.[92] Sometimes those waiting for a vaccination were turned away at the end of the day.[93]

One of Dr. Thorne's patients was a public health nurse, Ms. Michelle Bosch. Because she was one of the front-line nurses at the public clinics, he thought she might be a point of contact. He described his conversation with Ms. Bosch as follows:

> I'm a little bit concerned about the Calgary Flames showing up unannounced to one of your lineups. There should be some preparation. I have some concerns that people won't respect their space; that people won't respect their privacy; that there could be lineup control issues in an already stressed lineup; that innocent bystanders might be victims of some crowd issues.
>
> I just thought that knowing these guys, when they go to a restaurant or a public place, that all of a sudden there's a crowd there. And to be in a crowd for five hours I thought should take some planning. So that's why I placed a call to the nurse and asked what we could do about it. And she said she would take it to her supervisor and get back to me with a possible solution.
>
> I told her at that time that we want to be safe in the lineup. We do not want to be marched past the lineup. That can't be one of the solutions. You can't get us there and take us by … people who have waited five hours. I said that wasn't a solution. And just left it with her to take my concerns to her superiors, and that we were totally willing to line up; and if need be, the Calgary Flames would bring their own security to mitigate any crowd-control issues….[94]

Dr. Thorne told Ms. Bosch that he was concerned about the Flames being in a public lineup for five hours and that it would take some planning. He said, "It was never my intention to ask for a private clinic, an offsite clinic. I was just requesting how we get in this lineup safely." He also wanted Ms. Bosch to know that the Flames were coming and that, if she thought there would be a problem, the Flames would bring

[92] Testimony of Debbie Hyman, Transcripts, vol. 22, January 14, 2013, at 1770-72.
[93] Testimony of Debbie Hyman, Transcripts, vol. 22, January 14, 2013, at 1773-74.
[94] Testimony of James Thorne, Transcripts, vol. 19, January 11, 2013, at 1568-69.

their own security. He said he merely wanted Ms. Bosch to take these concerns to her supervisors.[95]

He said that Ms. Bosch responded to his concerns by saying, "I'll take this to my supervisors and see what they think about it and I'll get back to you."[96]

Michelle Bosch had begun working as a public-health nurse for AHS in 2008. In 2009 she was assigned to the Brentwood clinic. She knew that the H1N1 vaccine would be available beginning October 26 and that it would be available only through four designated clinics. Ms. Bosch stated that, sometime early in the week beginning October 26, she received a phone call from Dr. Thorne, who was a colleague of her husband. She said that Dr. Thorne wanted to have the Calgary Flames vaccinated and wanted to know how to go about it. She said his main concerns about the vaccinations were security for the team and people within the clinic, and privacy. Ms. Bosch said that, on hearing the request for help, her first reaction was "when he said he was thinking of bringing 50 people down for the vaccination, was: 'Oh, man, please don't come here.' Truly that was my original gut reaction."[97] She testified that her concern was the distraction that would be caused by the hockey team showing up at a public clinic. She told Dr. Thorne she would find out what he needed to do to have the team vaccinated.[98]

Ms. Bosch said she talked about security issues with Dr. Thorne because he raised that "first thing" in their conversation. And she replied, "Yes, security would definitely be an issue, and the security we had would not be adequate." She understood, however, that the Flames had security personnel and she said that Dr. Thorne told her that he could bring those security personnel. She told the inquiry that, even having Flames security personnel present would not "change the sideshow that was going on."[99]

She told Dr. Thorne she would have to check with someone higher up, since she had worked as an influenza nurse for only three weeks and "didn't know what the situation was or how things worked." Ms. Bosch stated that neither she nor Dr. Thorne suggested during their

[95] Testimony of James Thorne, Transcripts, vol. 19, January 11, 2013, at 1570-71.
[96] Testimony of James Thorne, Transcripts, vol. 19, January 11, 2013, at 1575.
[97] Testimony of Michelle Bosch, Transcripts, vol. 21, January 14, 2013, at 1722-23.
[98] Testimony of Michelle Bosch, Transcripts, vol. 21, January 14, 2013, at 1724-25.
[99] Testimony of Michelle Bosch, Transcripts, vol. 21, January 14, 2013, at 1726-27.

conversation that an alternative might be to administer the vaccine at a private or off-site clinic.[100]

Ms. Bosch first discussed the option of holding off-site vaccinations with Ms. Hyman. As noted, this did not come up in Ms. Bosch's initial conversation with Dr. Thorne, but she raised it with him in another conversation later that day. Ms. Bosch said it was her idea to do the vaccinations at Dr. Thorne's office.[101] Ms. Bosch said that she explained to Ms. Hyman that the Flames wanted to come as a group and be vaccinated. She said that Ms. Hyman told her that she [Hyman] was in no position to make any decisions about how the Flames would be vaccinated and that she would take the information higher and see what her superiors said.[102] Ms. Bosch said that she told Ms. Hyman of her idea about off-site vaccinations, so Ms. Hyman would have known about this idea when she called her superiors.[103]

Ms. Hyman said that vaccinating the Flames at the Brentwood clinic did not even enter her mind as a possibility because of the chaos at the clinic. Ms. Hyman approached the clinic's influenza manager, Ms. Sharon Berry, explained the request to vaccinate the Flames off-site, and asked her opinion. Ms. Hyman stated that Ms. Berry told her that this was something that Ms. Hyman should discuss with Micheline Nimmock, Ms. Hyman's director. Ms. Hyman telephoned Ms. Nimmock, but there was no answer. Ms. Hyman left a voicemail indicating that she had received a request to vaccinate the Flames off-site and that she was uncertain whether "we're able to go ahead and do this, but if you [Ms. Nimmock] have any issue with this, please call me and let me know." She testified that she thought she made the call to Ms. Nimmock the same day that Ms. Bosch approached her with the request about the Flames – Tuesday, October 27.[104]

Ms. Hyman did not receive a call back from Ms. Nimmock between the time of Ms. Hyman's call (Tuesday) and the day the vaccinations occurred (Friday). She recalled letting Ms. Bosch know that "there weren't any concerns and we were OK to go ahead." She stated that what she meant was that she had not heard from Ms. Nimmock to the contrary. If Ms. Nimmock had called and said not to proceed, Ms.

[100] Testimony of Michelle Bosch, Transcripts, vol. 21, January 14, 2013, at 1727.
[101] Testimony of Michelle Bosch, Transcripts, vol. 21, January 14, 2013, at 1730.
[102] Testimony of Michelle Bosch, Transcripts, vol. 21, January 14, 2013, at 1728-29.
[103] Testimony of Michelle Bosch, Transcripts, vol. 21, January 14, 2013, at 1730-31.
[104] Testimony of Debbie Hyman, Transcripts, vol. 22, January 14, 2013, at 1777-80.

Hyman would have "pulled the plug."[105] Ms. Hyman stated that, other than the message left for Ms. Nimmock and the discussion with Ms. Berry, she made no attempt to speak to any other superior for approval. Ms. Hyman reiterated later that she thought she had approval to proceed with the vaccination because she had not received any response to her voicemail for Ms. Nimmock.[106]

Ms. Lori Anderson, who later headed the investigation of the Flames incident for the AHS, largely confirmed this version of the attempt to obtain approval for the Flames vaccination:

> Well, what we determined was that there … were some inconsistencies, but that the manager [Hyman] had called and left a phone message stating to the effect that we're going to be holding a private clinic for the Flames and if you have any problems with that, let me know. If I don't hear, I'll assume it's OK.[107]

Ms. Anderson testified that no one above Ms. Nimmock was aware of the special clinic for the Flames.[108]

Meanwhile, Dr. Thorne believed that Ms. Bosch had taken the issue to her supervisors. He said that Ms. Bosch told him "they" took it to a higher level and another level. He said, "And a day later, Alberta Health Services conveyed to me that maybe being in a lineup isn't a good thing and is your clinic available?" Dr. Thorne said that Ms. Bosch conveyed this information to him.[109] No one else from AHS called him before the Flames' immunizations and he never asked to speak to anyone above Ms. Bosch about this. He assumed that people at a high enough level made the decision that it was OK, and that he did not have to talk to anyone else to confirm the decision to release flu shots for an off-site location.[110]

When Dr. Thorne made his initial request about the vaccine, he was planning only to vaccinate the players and the travelling staff – the managers and trainers who go on road trips with the team. He said this

[105] Testimony of Debbie Hyman, Transcripts, vol. 22, January 14, 2013, at 1780-81.
[106] Testimony of Debbie Hyman, Transcripts, vol. 22, January 14, 2013, at 1799-1800.
[107] Testimony of Lori Anderson, Transcripts, vol. 22, January 14, 2013, at 1807.
[108] Testimony of Lori Anderson, Transcripts, vol. 22, January 14, 2013, at 1807-08.
[109] Testimony of James Thorne, Transcripts, vol. 19, January 11, 2013, at 1575.
[110] Testimony of James Thorne, Transcripts, vol. 19, January 11, 2013, at 1575-76.

would be between 50 to 70 people. However, he said, sometime during the week, Ms. Bosch suggested vaccinating the families. He did not think it was Ms. Bosch's idea. He thought she was conveying the views of AHS. He testified that AHS had suggested that any leftover vaccine would deteriorate very quickly.[111] He then let the players know that they could bring their families the same day if they wanted them to receive the vaccine. A signup sheet was placed in the training room and that gave an idea of how many people would come to his Friday clinic. He received this list on the Friday morning and passed it on to Ms. Bosch before those wanting the vaccine arrived at his clinic. The vaccines were administered at LifeMark, the clinic rented by Dr. Thorne. Dr. Thorne estimated that about 150 people were vaccinated, including him and his daughter.[112]

He summarized the chronology of events:

> It's the end of October. So the vaccine was released on Monday to the big lineups. On Tuesday I had the conversation with Michelle [Bosch]. On Wednesday she got back that we could have the clinic. Wednesday night, I talked to the Flames management about it. Thursday my office was jam-packed. I was busy, busy, busy that day. And then had patients Friday morning, and then Friday afternoon we had the players and their families come.[113]

Dr. Thorne said that, since the nurses were volunteering and were not scheduled to be at the Brentwood clinic that Friday afternoon, the Flames' vaccinations did not reduce manpower at Brentwood. Two nurses came, one of whom was Ms. Bosch. Two nurses from his office and the receptionist also volunteered their time to help.[114]

Ms. Hyman stated that patient records created as part of the normal vaccination process were stamped ahead of time with Brentwood clinic, not LifeMark. She did not consider scratching out the Brentwood clinic stamp and putting in LifeMark as the clinic where the vaccinations occurred because the vaccine came from Brentwood. She did not tell any of the vaccine recipients that, if they were asked, they should say

[111] Testimony of James Thorne, Transcripts, vol. 19, January 11, 2013, at 1579-80.
[112] Testimony of James Thorne, Transcripts, vol. 19, January 11, 2013, at 1583 and 1588-89.
[113] Testimony of James Thorne, Transcripts, vol. 19, January 11, 2013, at 1578.
[114] Testimony of James Thorne, Transcripts, vol. 19, January 11, 2013, at 1586-87.

they received their vaccinations at Brentwood. Nor did she hear Ms. Bosch give such instructions. Ms. Hyman also stated that no one attending the clinic that day expressed concerns to her about whether it was proper to be receiving the vaccines at a private clinic.[115] However, Ms. Hyman said, she overheard Dr. Thorne telling people, "If you're asked, just say that you … received your vaccine at Brentwood." She said she did not know that this was the message he wanted delivered until she heard him say this. She said she asked him why he was telling people to say this, "because we have received approval to … be here and to do this." She was "really confused" as to why Dr. Thorne would be saying this. She said that Dr. Thorne did not give her a response.[116]

Ms. Anderson testified that, in conducting the investigation: "Everybody was told that if you're asked, that you say you were – you received your immunization at the Brentwood clinic. And … somebody expressed that we do not want this to get out to the media. And I think that it wasn't to trace for adverse reactions; I think it was that they didn't want it to be known that they held a private clinic for the Flames." Ms. Anderson said she did not accept the explanation that the vaccination forms were stamped Brentwood clinic because that is where the vaccine originated.[117]

Dr. Thorne's recollection of how the Brentwood stamp was being explained differs from that of Ms. Hyman and Ms. Anderson. Dr. Thorne knew that obtaining the vaccine was "a big process" and that the vaccine and syringes came from the Brentwood clinic. He understood that paperwork was completed to show the Brentwood clinic as the location at which the vaccines had been given. The staff members who volunteered their time to vaccinate the players came from that clinic. The supplies were from that clinic and the paperwork would appear as if "we" got the vaccine at the Brentwood clinic. He was asked if he spoke with Ms. Bosch or any of the other nurses about the part of the forms saying that the vaccine had been given at Brentwood. Dr. Thorne said that he had and that they said, "We're the nurses from there; the vaccines [are] from there; the paperwork's going to be from there." Dr. Thorne did not see the paperwork mentioning Brentwood as an issue at the time.[118]

[115] Testimony of Debbie Hyman, Transcripts, vol. 22, January 14, 2013, at 1789-90.
[116] Testimony of Debbie Hyman, Transcripts, vol. 22, January 14, 2013, at 1790-91.
[117] Testimony of Lori Anderson, Transcripts, vol. 22, January 14, 2013, at 1809-10.
[118] Testimony of James Thorne, Transcripts, vol. 19, January 11, 2013, at 1583-86.

Dr. Thorne stated that there was no type of payment by him or the Flames organization beforehand to the nurses for their work or the vaccine. However, because people had worked so hard for three hours, he asked if he could do anything for them. He said, "So there might have been something [as] an appreciation token after the fact." He offered some game tickets. He said, "I can't remember if it was money. I know it was probably tickets … after the fact."[119] Dr. Thorne said the nurses refused the tickets, saying they were just volunteers. "They wouldn't take anything," he said.[120]

Dr. Thorne first realized the potential for controversy about the Flames' vaccinations the following day. He read in the newspaper that the vaccine was being withdrawn due to shortages and that they were going to prioritize who received the vaccine. He had no prior knowledge of a shortage.[121] On learning of the shortage, he concluded "this is going to be bad," because the Flames were not in a lineup and now there was a shortage. He thought that news of the Flames' vaccination would reach the public. He said that, if he had known there would be a shortage, he would not have proceeded with the Flames' vaccination.[122]

Dr. David Megran was the lead of three executive members designated to head the AHS response to the H1N1 epidemic and the recovery phase that would follow. He said he first learned of the Flames' vaccinations on Monday, November 2, when AHS communications staff alerted him that the media had reported the vaccinations that day.[123]

Dr. Megran stated that an AHS investigation quickly followed because of the media attention and the seriousness of the issue. The conclusions of the investigation were relayed to him orally on November 4 or 5. The vice-president in charge of the investigation, Ms. Lori Anderson, reported to Dr. Megran that two people directly involved in how the vaccinations unfolded had been fired.[124] There was also a referral to the College of Physicians and Surgeons asking it to consider investigating Dr. Thorne's involvement.

[119] Testimony of James Thorne, Transcripts, vol. 19, January 11, 2013, at 1589.
[120] Testimony of James Thorne, Transcripts, vol. 19, January 11, 2013, at 1591.
[121] Testimony of James Thorne, Transcripts, vol. 19, January 11, 2013, at 1593.
[122] Testimony of James Thorne, Transcripts, vol. 19, January 11, 2013, at 1593.
[123] Testimony of David Megran, Transcripts, vol. 3, December 4, 2012, at 214.
[124] Testimony of David Megran, Transcripts, vol. 3, December 4, 2012, at 215-16.

The results of the College investigation were reported in a letter of December 21, 2009, to Dr. Megran. The investigation concluded as follows:

> The Investigation Chairman has reviewed this matter and concluded that Dr. Thorne's decision constitutes an error in judgment, not professional misconduct or lack of judgment. It is noted that Dr. Thorne's intent was to help his patients. As a result, the Investigation Chairman has directed that this complaint be closed. The public reaction to this incident as well as the complaint has served as very useful feedback to Dr. Thorne regarding the ethics of seeking preferred services for an elite group of individuals in a publicly funded health care system….[125]

Inquiry findings

This episode is a clear-cut case of improper preferential access, since the Flames' players, family and staff avoided long lineups at the public vaccination clinics. It is interesting to note that, while the public understood this to be queue-jumping, the College did not view it that way. It was merely an "error in judgment" on Dr. Thorne's part. Similarly, the AHS investigation that resulted in the termination of Ms. Hyman's employment as well as that of her director, Ms. Nimmock, characterized the event as "exceedingly poor judgment" on their part. However, AHS did not directly describe this incident as one of improper access. Ms. Anderson testified that these two individuals were not terminated for holding the clinic.[126]

The public reaction to this incident demonstrated that the popularity of these athletes in the community does not translate into public acceptance of their entitlement to preferential access to publicly funded health services.

I understand Dr. Thorne's interest in finding some way to vaccinate the players with a minimum of bother. I also understand the reaction of the clinic nurse and manager that led them to accommodate this request. In their view, having the players attend a public clinic would create further chaos in an already difficult environment. On the other hand, as Ms. Anderson suggested in her testimony, having the players line up

[125] Exhibit 85.
[126] Testimony of Lori Anderson, Transcripts, vol. 22, January 14, 2013, at 1811.

with the public would have sent a positive message to all Albertans to get vaccinated despite the inconvenience.

I mention this because there are different ways to view the problems posed by vaccinating these high-profile athletes. If Ms. Bosch, Ms. Hyman and Ms. Nimmock had taken steps to notify senior AHS management of this request, management would at least have had an opportunity to reflect on the options. If a decision were then made to hold a private clinic, it might have been possible to justify the decision to the public. As it was, the private clinic process clearly violated AHS restrictions limiting vaccinations to the four designated public clinics.

The Calgary Flames vaccination incident may be a one-of-a-kind occurrence. Still, this problem might never have arisen if AHS had a policy at the time on dealing with special requests. That, of course, begs the question of how prepared AHS was for the H1N1 pandemic, something beyond my mandate to examine.

Recommendation 9:

Develop a policy on special accommodation during a pandemic

As part of any pandemic preparedness plan, Alberta Health Services should develop a policy on how to address requests for special accommodation.

5. *Nurses and the H1N1 vaccine*

The inquiry heard evidence about other issues arising from the H1N1 vaccination program in 2009. Some of it concerned nurses working in the Edmonton area who:

- expedited the vaccination of family members at the public immunization clinics;
- vaccinated individuals after hours;
- vaccinated individuals after the program had been halted; or
- took vaccine home to vaccinate family and friends.

The inquiry also heard evidence about possible improper preferential vaccination of AHS employees in Red Deer.

a) *Nurses vaccinating friends and family*

Linda Duffley is the director of public health programs for the Edmonton area, a position she held in 2009 during the H1N1 crisis. Ms. Duffley testified that the H1N1 vaccination program was rolled out on October 26, 2009. The vaccine had never been administered before and involved an "adjuvenated vaccine." Nurses were unfamiliar with this type of vaccine, which had to be reconstituted, or mixed together, before being administered. Once it was reconstituted, it had to be used within 24 hours or it was no longer usable.[127]

In the initial week of the vaccination program, the H1N1 vaccine was to be administered at eight large urban sites within the Edmonton zone. Some sites were located in existing clinics, but the majority were in leased space within large public areas to accommodate the expected volumes. Ms. Duffley described long lineups, altercations in the lineups, the use of threats to get to the front, an anxious public and, in general, a stressful situation, the likes of which she had never experienced in her nursing career.[128] Other witnesses gave similar descriptions.

Ms. Joy Lohan is the manager of the province-wide immunization program, standards and quality, a position she has held since July 2009. During the H1N1 crisis, Ms. Lohan's responsibilities included managing the vaccine supply from central depots in both Edmonton and Calgary. On October 31, 2009, she learned that all clinics would be temporarily closed for an indefinite period due to an apparent shortage of vaccine supply. At that point, Ms. Lohan turned her mind to what to do with the vaccine that was still on hand.

On a typical day, both the mixed and unmixed vaccine would remain at the clinics and be put in fridges for use the next day. With the clinics closed indefinitely, Ms. Lohan was concerned about the safety of the vaccine supply if this protocol were followed. These sites did not have backup generators or alarms on the refrigerators that would activate if the electricity was cut off. The central depots, though, did have backup generators and alarm systems to ensure the vaccine would not be

[127] Testimony of Linda Duffley, Transcripts, vol. 27, January 17, 2013, at 2188-89.
[128] Testimony of Linda Duffley, Transcripts, vol. 27, January 17, 2013, at 2189-93.

wasted in a power outage. For that reason, she decided to have all the unreconstituted vaccine brought back to the central depots. She said, "I did not know when we were going to start the clinics again, and I didn't want to risk a cold chain break at one of the public health centres."[129] Her instruction was communicated to the clinics, either directly by Ms. Lohan to the clinical development nurses in charge (CDC) or by one of her staff members.

She gave no instructions about what to do with already-mixed vials of vaccine. Ms. Lohan's concern lay in making sure that the supply on hand was secured. Asked if she had told the nurses anything that could have suggested they had permission to take the mixed vials for their personal use, either to inoculate family or others after the public lines closed, Ms. Lohan replied, "not that I recall." She added, "To be honest with you, I was so concerned about getting the unreconstituted product back, I didn't think about it."[130]

Judy Brosseau is the manager of the Northgate clinic in Edmonton and has been since 1995. During the first four days of the mass H1N1 immunization clinic, Ms. Brosseau worked Wednesday through to Saturday. She described the atmosphere as busy, especially the Saturday, when the mall was full of people and "unfriendly." She recalled one incident before October 31 involving a staff member she encountered in the hallway, who was accompanied by her family. She was introduced to the family. After the family left, Ms. Brosseau asked the nurse what they were doing there. She discovered they were there to get vaccinated, outside of the public line. It did not cause her concern because the nurse "would have been doing it on her own time," said Ms. Brosseau, referring to a lunch or 15-minute break or after the centre had closed. Counsel asked her if, from her perspective as clinic manager, nurses had approval to bring in and vaccinate their families, and as long as they were doing so on a break, it was not an issue. She replied, "That's right."[131]

Ms. Brosseau testified that Linda Duffley contacted her and asked whether nurses were immunizing family members outside the line. Ms. Brosseau responded that she was aware of one incident. While she could not remember the exact words, she said the direction from Ms.

[129] Testimony of Joy Lohan, Transcripts, vol. 27, January 17, 2013, at 2244-45.
[130] Testimony of Joy Lohan, Transcripts, vol. 27, January 17, 2013, at 2251.
[131] Testimony of Judy Brosseau, Transcripts, vol. 28, January 18, 2013, at 2270-72.

Duffley was "to the effect of 'Not to do that again,' or 'To let staff not to do that.'" She said the communication was oral and there was no documentation. Asked if it surprised her to be told this, Ms. Brosseau said, "Nothing surprised me in H1N1 at any point because everything was changing hourly at times. So nothing surprised me in H1N1." No one was disciplined because there was no written policy to enforce.[132]

Ms. Duffley testified about a rumour that family members had bypassed the line at the Northgate clinic. Upon investigating, she received confirmation from the operations manager of the clinic that nurses' family members had bypassed the line. "Her understanding was that we had permission for that to be occurring," she testified.[133] Ms. Duffley informed her executive director, who said the manager needed to be told that this could not continue. Ms. Duffley told the executive director that she had already explained this to the manager. No further effort was made at the time to inform other clinics. A memorandum was issued to all clinics, but months after the incident. The memo, dated January 25, 2010, said in part:

> This memo is to communicate expectations regarding immunization of family members by staff.
>
> Family members of staff are to access immunization in the same manner as the public. Family members are not to receive preferential or special treatment.
>
> Under no circumstances is vaccine to be taken home or administered outside of established Public Health programs, clinical settings and clinic hours.[134]

Asked why she waited so long to send the memo, Ms. Duffley responded, "Because, again, things were very hectic – this was sent out after the [alleged third] incident at the Westmount site when we determined that maybe we had a pattern rather than just one or two single situations." She also explained that the memo applied to all immunization programs, not just H1N1.[135]

[132] Testimony of Judy Brosseau, Transcripts, vol. 28, January 18, 2013, at 2273-74.
[133] Testimony of Linda Duffley, Transcripts, vol. 27, January 17, 2013, at 2210.
[134] Exhibit 114.
[135] Testimony of Linda Duffley, Transcripts, vol. 27, January 17, 2013, at 2212.

Ms. Christine Westerlund was the southeast regional manager in the primary care division during the H1N1 crisis. She testified that nurses at some sites were vaccinating their families during breaks. She had no concerns at the time "because there was no clear direction that that was not an acceptable practice. And we were really actually focused on trying to have as many, I'm going to say, the manpower available to serve the public." Ms. Westerlund said this rationale included the attempt to prevent nurses from being home with a sick child in their immediate family, or off for half a day or longer, standing in line to get their children immunized.[136]

Ms. Brosseau also testified that she personally vaccinated friends of her daughter after the clinics were closed on October 31. She described the day as "very chaotic," with 3,000 to 4,000 people in and outside the mall where the clinic was located. As the 4 p.m. closing time neared, Ms. Brosseau was paying close attention to the number of unused vials. She did not want to waste any vaccine. The clinic then received a supply of mixed vaccine from another site. Ms. Brosseau could not recall the number of vials that remained at 4 p.m., but believed there were about 86 doses, "which really troubled me because they would then all be discarded."[137]

Ms. Brosseau testified she took one vial home and did not know what happened to the rest. The CDC nurse would have been responsible for the remaining doses, she said. Wanting to use the vaccine, she thought she would use them on "contacts" of her daughter. Asked if this were fair, administering doses to her daughter's friends, that evening at home, Ms. Brosseau replied yes. She added, "I considered it like a home visit, which we do do with vaccinations." She believes she documented the vaccinations on the required forms and later submitted them with the other counting sheets.[138]

Ms. Duffley was asked if she believed it appropriate for a clinic manager to take vaccine home and vaccinate her daughter's friends. She replied:

> Well, we were in a situation where we had a national shortage and we didn't want to waste any doses of vaccine. So I don't

[136] Testimony of Christine Westerlund, Transcripts, vol. 28, January 17, 2013, at 2290-91.
[137] Testimony of Judy Brosseau, Transcripts, vol. 28, January 17, 2013, at 2277-80.
[138] Testimony of Judy Brosseau, Transcripts, vol. 28, January 17, 2013, at 2279-81.

> know if that makes it more correct, but we have always, in public health, been very, very concerned about our vaccine supply and not wasting any doses of vaccine.[139]

Ms. Duffley confirmed she had never authorized any clinic manager to take vaccines home after the lines shut down.[140]

Ms. Westerlund was also asked if Ms. Brosseau's conduct was acceptable. She replied:

> I was not aware of that at the time, so I probably can't comment if that would be acceptable or not. We do not like to waste vaccine. That is something that's ingrained in us all the way throughout, not just in an H1N1 campaign, that we were always cautious not to waste vaccine.[141]

Ms. Susan Smith is the clinical development nurse of communicable disease control at the Bonnie Doon Public Health Centre in Edmonton. Her job at the mass clinic during the week of October 26 to 31, 2009 was quality assurance of the vaccine supply.

Ms. Smith testified about what happened at the clinic on November 1, 2009, the day after the vaccine program shut down indefinitely at the mass clinics. She said she returned to the clinic with the leftover vaccine that was going to expire at 1 p.m., and opened the doors to 15 people – who did not wait in line to be inoculated. She testified she would do the same thing again today under similar circumstances because the situation was a crisis and she did not want vaccine to go to waste. It was instilled in her on a daily basis not to waste vaccine. She testified her instructions were clear: "Whatever you do, minimize wastage. We are short. Don't waste vaccine."[142]

As the person responsible for bringing the vaccine to the site, Ms. Smith was directed, she believes by her supervisor Joy Lohan, to bring the remaining vaccine back to the vaccine depot at the central location on October 31. She does not recall if she was clearly directed to bring back all the vaccine, including the vials that were already mixed. Those mixed vials she left at the clinic in the "biological" fridge. The rest she

[139] Testimony of Linda Duffley, Transcripts, vol. 27, January 17, 2013, at 2214-15.
[140] Testimony of Linda Duffley, Transcripts, vol. 27, January 17, 2013, at 2215.
[141] Testimony of Christine Westerlund, Transcripts, vol. 28, January 17, 2013, at 2289.
[142] Testimony of Susan Smith, Transcripts, vol. 27, January 17, 2013, at 2222-29.

took back to the central depot. The next day, her day off, she went back to the clinic "so the vaccine would not go to waste." To ensure it was used, she spoke with staff "to see if we could get people in; or if they had received vaccine, that we could use the vaccine before it was discarded." The doors were locked and the clinic was not open to the public, but staff were there working, by appointment only, with mothers and their newborn babies.[143]

Ms. Smith could not remember calling friends or family, or how they got people to the clinic, but she documented 15 vaccinations on the morning of November 1.[144] She did not immunize her own children, as they had already received their vaccine. She did not recall if the others were acquaintances, or how she knew them. According to her records, she vaccinated one AHS employee, five children between the ages of five and nine, three children between the ages of 10 and 18, and seven adults between 19 and 64.[145] She documented the cases but backdated the report to October 31, even though the immunizations occurred November 1. Ms. Smith said that backdating documentation was not an uncommon practice.

Ms. Smith was asked if she had any concerns at the time that unlocking the door and letting people get vaccinated who had not stood in line was unfair to those who had been turned away the day before. She replied:

> We were in a crisis. We were in an emergency situation, and we had a very limited resource that we did not want to waste. My feeling was not to waste the vaccine, and that was more important than anything, really, and it concerned me gravely that we may be wasting vaccine that people could use.[146]

Ms. Lohan recalled having a discussion with Ms. Susan Smith, who contacted her by telephone on Saturday, October 31, to give her a heads-up that clinics would close at day's end. She does not remember

[143] Testimony of Susan Smith, Transcripts, vol. 27, January 17, 2013, at 2228-29.
[144] Exhibit 116.
[145] Testimony of Susan Smith, Transcripts, vol. 27, January 17, 2013, at 2230; Exhibit 116.
[146] Testimony of Susan Smith, Transcripts, vol. 27, January 17, 2013, at 2234.

saying anything to Ms. Smith that would indicate Ms. Smith could use the mixed vaccine after the clinics closed.[147]

Ms. Westerlund also testified about the November 1 incident. She went to the Bonnie Doon site on October 31, but did not discuss what to do with the open vials of vaccine until near the end of the day. She spoke with Ms. Smith about the plan to use up the vaccine so there would not be wastage.[148] She recalled discussing with Ms. Duffley what should be done with the vaccine that was open, and having a conversation about how it might be used the next day, but did not recall the outcome of that discussion. Ms. Westerlund admitted that she might have left Ms. Smith with the impression that it was fine to use the vaccine the next morning. About the November 1 incident, Ms. Westerlund explained there "was no real clear direction and that was probably why, when the question came and there was a discussion, I didn't have a clear answer and had wanted to consult with someone else."[149]

As previously noted, by October 30 there were concerns of a vaccine shortage and it was decided to close the clinics indefinitely at end of day on Saturday, October 31. Nurses were being asked to share vials of vaccine to prevent wastage. They were also being told to use up each vial before reconstituting more vaccine.

At some point, Ms. Duffley and her counterpart on the standards and quality side, Ms. Lohan, had a conversation in which they discussed what to do with the partly used vials of mixed vaccine. They discussed the possibility of immunizing the staff who had not yet been vaccinated, who could be immunized "because we had permission for our staff to be immunized." Asked if that permission extended to family, friends or acquaintances of staff, Ms. Duffley said, "Not that I can recall. I know we did talk about what public health programs might be running on the Sunday, and we tried to look to see whether there was a way for any of those patients or clients to have the service, and we really weren't able to come up with a solution." Ms. Duffley

[147] Testimony of Joy Lohan, Transcripts, vol. 27, January 17, 2013, at 2251-52.
[148] Testimony of Christine Westerlund, Transcripts, vol. 28, January 17, 2013, at 2287-88.
[149] Testimony of Christine Westerlund, Transcripts, vol. 28, January 17, 2013, at 2287-89.

accepted that there would be small amounts of wastage because they were not able to open the lines "safely."[150]

Asked if it was acceptable for nurses to use the vaccine for family or acquaintances, Ms. Duffley said there was no policy one way or the other. She clarified that she had never intended to convey otherwise to Ms. Lohan or to suggest that it would be acceptable for nurses to take the vaccine for personal use. She said her "personal belief" is "that we should not benefit from our own – from our employment situation."[151]

In contrast, Ms. Lohan said she believes that provincial pandemic plans should be rewritten with a clause that says staff and their family should be protected because staff is a "very important resource" when it comes to immunizing 3.3 million Albertans in a pandemic. She said:

> We need our staff to provide immunization, we need our staff to provide health care. We know that with influenza, children are transmitters of the virus. And I feel – and this is just my personal opinion – that we should write into our pandemic plan how our staff and families should be protected so that we have that resource to use to provide care and to provide immunization programs.[152]

Inquiry findings

Here we have several instances of preferential access to immunization. Nurses gave that preferential access when they vaccinated family and friends by helping them bypass lines at the public clinics, by vaccinating them after hours or on their breaks, and by taking vaccine home. The rationale in some cases was a desire to avoid wastage of the reconstituted vaccine. In other cases, the rationale was simply that there was no policy or direction to govern the situation. There was also no consensus among supervisory staff. It was not until January 2010, when shortage of vaccine was no longer an issue, that a directive was issued specifying that family members of staff were to be immunized in the same manner as the public.

Given the limited shelf life of the vaccine, it can be argued that the nurses' actions, at least after the announcement that the clinics were

[150] Testimony of Linda Duffley, Transcripts, vol. 27, January 17, 2013, at 2202.
[151] Testimony of Linda Duffley, Transcripts, vol. 27, January 17, 2013, at 2204-05.
[152] Testimony of Joy Lohan, Transcripts, vol. 27, January 17, 2013, at 2253.

closing, were pragmatic actions designed to immunize as many people as possible before the vaccine became unusable. But, of course, the choice of who received the vaccine was solely at the discretion of the nurses. Besides, they had an alternative. They could have kept the public lines open longer until all the reconstituted vaccine had been used.

The closing submissions of AHS describe these incidents as "an illustration of how extraordinary circumstances raise questions and demand judgments that do not always have policies readily available for guidance."[153] These were circumstances that could and should have been foreseen.

In December 2010 the Health Quality Council of Alberta released its report reviewing Alberta's response to the H1N1 pandemic.[154] That report noted that designated staff immunization clinics were established within AHS facilities as soon as the vaccine was available. These clinics opened on October 22, 2009, and closed temporarily on October 31 when the mass public clinics closed. The rationale for immunizing health care workers early was to prevent an infected health care worker from spreading the infection to others and to minimize absenteeism.[155]

The report also refers to an "ethics framework" that uses an application of principles to help guide clinical and operational decision-making instead of a prescribed set of policies. This type of tool would have helped health care workers resolve the questions raised by extraordinary circumstances (as they were described in the AHS submission). The AHS Rapid Response Clinical Ethics Consultation Service was apparently developed to provide resources for difficult decision-making during the pandemic but, according to the report, was not used. Instead, individuals sought out those familiar to them to help resolve problems or were referred to an individual ethicist.[156]

The Health Quality Council of Alberta report recommended that Alberta Health and AHS develop and maintain an ethical framework

[153] Closing Submissions of Alberta Health Services, April 1, 2013, at 16 (Exhibit 164).
[154] Health Quality Council of Alberta, *Review of Alberta's Response to the 2009 H1N1 Influenza Pandemic* (December 2010).
[155] Health Quality Council of Alberta, *Review of Alberta's Response to the 2009 H1N1 Influenza Pandemic* (December 2010) at 39 and 50.
[156] Health Quality Council of Alberta, *Review of Alberta's Response to the 2009 H1N1 Influenza Pandemic* (December 2010) at 61-62.

and strategies to guide operational and clinical decision-making.[157] I support this recommendation. Two considerations should go into such a framework: (1) the extent of discretion that a front-line health care worker, such as a nurse at an immunization clinic, should have to make the type of decisions that the nurses involved in these incidents made; and (2) whether the families of such front-line workers, especially since children should be considered high-risk,[158] should be given priority for immunization like health care workers. Without such a framework, front-line workers are left to make difficult decisions on the spur of the moment and without guidance.

The conduct of the nurses in immunizing family and friends outside of clinic hours and away from clinic premises, and expediting the vaccination of family members at clinics while nurses were on breaks, without permission from superiors, constituted improper preferential access. Ethically, it was no different in essence than the private immunizations of the Calgary Flames discussed earlier.

b) *Red Deer immunizations*

The inquiry heard conflicting evidence about an incident involving possible improper preferential vaccination of AHS employees in Red Deer. The conflict was between the evidence of two individuals. Ms. Kelly Marie Hawken was the executive assistant to the executive director of rural hospitals for AHS at around that time. Ms. Jennifer Currie was Director, Central Zone Emergency Operation Centre (EOC), during the first 13 days of the H1N1 emergency and for several days in the weeks that followed. Ms. Hawken testified before the inquiry, while Ms. Currie submitted a statutory declaration.[159]

Ms. Hawken said that about 100 AHS employees worked at the Michener Bend Building in Red Deer. No front-line doctors or nurses worked there, though some of the administrators were nurses. On the lower level of the building was an emergency centre dedicated to H1N1 vaccinations. She understood the centre had arranged the original setup

[157] Health Quality Council of Alberta, *Review of Alberta's Response to the 2009 H1N1 Influenza Pandemic* (December 2010) at 62.
[158] The Health Quality Council of Alberta's report noted that the Public Health Agency of Canada identified children from six months to less than five years of age as falling within the high-risk population for the H1N1 pandemic: *Review of Alberta's Response to the 2009 H1N1 Influenza Pandemic* (December 2010) at 34-35.
[159] Exhibit 158.

of the public vaccination clinics and was taking calls if emergencies happened in the clinics. She understood that those working in the centre did not deal with the public and were not front-line workers. According to Ms. Hawken, only about four or five people worked there.[160]

Ms. Currie stated that most of those working in the EOC worked long hours, from very early in the morning to late at night, six days a week. These people ensured that staff required for emergency responses in communities were recruited, deployed, assigned and trained to care for patients and to work in immunization clinics. The EOC staff also arranged procurement and distribution of supplies under demanding conditions. They arranged to move supplies and vaccines across Central Zone, booked and rebooked venues and arranged to move equipment in and out of clinics. They responded to each crisis as it was reported to them and coordinated communications of all kinds. According to Ms. Currie, workers at the EOC during this time often went back to their offices after the working day to respond to inquiries that they could not manage during normal hours.

Ms. Hawken said that the lineups in the early days of the H1N1 vaccination program in Red Deer were "huge."[161] At about the time the lineups were occurring, the executive assistant to the vice-president of Central Zone announced to those in the Michener Bend Building that public health nurses would be coming to vaccinate everyone. Ms. Hawken said she was told that, because those in the EOC did not have time to stand in line to be vaccinated, public health nurses were coming to vaccinate them and everyone else in the building. She understood from the nurses doing the vaccinations that Ms. Currie gave the order to vaccinate.[162]

Ms. Currie said she became involved in discussions about how those involved in the Central Zone EOC could get immunized. The rationale was that the staff were critical to support a pandemic response and that the hours they were working did not in many cases allow them to get access to the mass clinics for immunization. She stated, "Based on information available at the time, I approved the implementation of arrangements to provide on-site immunization."

[160] Testimony of Kelly Marie Hawken, Transcripts, vol. 34, February 20, 2013, at 2802-06.
[161] Testimony of Kelly Marie Hawken, Transcripts, vol. 34, February 20, 2013, at 2803.
[162] Testimony of Kelly Marie Hawken, Transcripts, vol. 34, February 20, 2013, at 2807-08.

Inquiry findings

Ms. Currie's statutory declaration is consistent with Ms. Hawken's recollection, although Ms. Currie did not indicate that the vaccinations were to be for everyone in the building. Her declaration stated that the immunization clinic was held at the building for EOC members. She said that other members of the AHS staff in the building may have had access to the immunizations as well. In fact, Ms. Hawken said she too received the immunization there.[163]

What is clear from both of these versions of this incident is that there were other AHS personnel in the Michener Bend Building besides those working in the EOC and they received vaccinations. Again, there was no policy about who should be vaccinated, in what priority, or about which circumstances would justify an exception to the arrangements made for ordinary members of the public. According to Ms. Hawken, three nurses showed up at the building, apparently on their way to the public clinics, but instructed to immunize the people working there first.[164]

The Health Quality Council of Alberta's report on the H1N1 pandemic response noted how it is critical in a pandemic to have an understanding of which individuals are considered as first responders and essential services and whether they comprise part of the high-risk group for immunization. This was not clear during the immunization campaign in Alberta. Emergency medical service personnel who were AHS staff or contracted service providers received immunization at the AHS staff clinics starting October 22, 2009.[165] My assessment of the evidence of this incident is that it occurred during the first week of the mass immunization clinics, the week of October 26. The Health Quality Council of Alberta recommended that Alberta Health and AHS collectively define those groups who should be considered high priority and then achieve consensus on their prioritization. More important, this

[163] Testimony of Kelly Marie Hawken, Transcripts, vol. 34, February 20, 2013, at 2809.
[164] Testimony of Kelly Marie Hawken, Transcripts, vol. 34, February 20, 2013, at 2808-10.
[165] Health Quality Council of Alberta, *Review of Alberta's Response to the 2009 H1N1 Influenza Pandemic* (December 2010) at 39.

exercise must be based on facts and supported by public health experts.[166]

I support these recommendations. It may have been appropriate to make special efforts to immunize those working in the Emergency Operation Centre in Red Deer, but there was no justification for doing so for non-essential administrative personnel. Such vaccinations constituted improper preferential access.

6. *Emergency care and triage procedures*

Emergency department care, and in particular an ever-increasing demand on emergency services and unacceptable wait times for service, has been a major concern for public health care systems in Canada for years. The Health Quality Council of Alberta has conducted two reviews of these issues in the past six years.[167] The inquiry heard evidence about emergency room procedures with a view to identifying possible improper preferential access. It also heard evidence about a practice, referred to in the inquiry as the private patient path, whereby emergency departments can be used to facilitate access for some patients.

When patients arrive at an emergency department, they are prioritized and then treated according to the urgency of the care they require. The initial assessment is usually done by a triage nurse. This assessment includes checking vital signs, getting a medical history and calculating a level of illness category under the Canadian Triage and Acuity Scale (CTAS) system. The CTAS has five levels of acuity. Patients requiring immediate supervision and possibly resuscitation are assessed as CTAS level 1. CTAS 2 (emergent) and CTAS 3 (urgent) categories represent patients needing more timely attention than those categorized as CTAS 4 (less urgent) and CTAS 5 (non-urgent).[168] Once a CTAS number is assigned, patients wait to be seen by an emergency department physician who co-ordinates the necessary care.

[166] Health Quality Council of Alberta, *Review of Alberta's Response to the 2009 H1N1 Influenza Pandemic* (December 2010) at 39-40.

[167] Health Quality Council of Alberta, *Review of Emergency and Urgent Care Services in the Calgary Health Region* (September 2007); Health Quality Council of Alberta, *Review of the Quality of Care and Safety of Patients Requiring Access to Emergency Department Care and Cancer Surgery and the Role and Process of Physician Advocacy* (February 2012).

[168] J.L. Saunders & Associates Inc., *How Health Care is Delivered in Alberta* (November 29, 2012) at 12 [Exhibit 12].

I heard evidence from several witnesses, all of them with many years of experience in emergency departments either as nurses, directors or managers, or as physicians. All the witnesses testified to similar procedures in emergency departments.

Patients are triaged in the same manner no matter how they arrive at the emergency department – by ambulance, accompanied by police or arriving on their own. Still, the triage process is a source of confusion and patient complaints. Ms. Sheri Drozda, a nurse clinician at the Foothills Hospital emergency department in Calgary, explained that patients often perceive triage as queue-jumping. They complain about it "all the time," despite her efforts to explain the triage system.[169]

Ms. Drozda believes some confusion results from the procedural work done in the emergency area. The waiting rooms are close together "and everybody is watching everybody because you're sitting there and waiting, and that's pretty much what you're doing." They see the nurse-initiated protocols, such as blood testing, X-rays being ordered, or IV hook-ups, and believe those people are moving through the system more quickly. She said, "That generally isn't the case. Sometimes we're just starting treatment, but they're still waiting in order of their priority of when they came in."[170]

The perception of the triage process as queue-jumping stems from the fluidity of the triage system, said Ms. Drozda. This perception arises particularly when someone with an urgent condition comes in and bumps someone with a less urgent condition down the list. She said she often hears complaints to this effect: "I was told an hour ago that I was fourth to be seen and now I'm seventh. Why is that? I've already been here for four hours."[171] She explained, "Generally it's because somebody has come into the department that was sicker than them and so they've been bumped down. That's usually why there's a wait."[172]

The witnesses also described common unwritten practical considerations, apart from CTAS ranking, in determining a patient's position in the queue. Ms. Kathy Taylor, a triage nurse and manager at the Peter Lougheed Medical Centre in Calgary, talked about preferential service for infants and young children. She said, "Part of

[169] Testimony of Sheri Drozda, Transcripts, vol. 5, December 5, 2012, at 330.
[170] Testimony of Sheri Drozda, Transcripts, vol. 5, December 5, 2012, at 330-31.
[171] Testimony of Sheri Drozda, Transcripts, vol. 5, December 5, 2012, at 331.
[172] Testimony of Sheri Drozda, Transcripts, vol. 5, December 5, 2012, at 331.

our preferential [access] for children is that we don't want them in our world because it's not a clean world, and so … a lot of our children, we do get through quicker. Plus crying babies are not a good thing to have in your waiting room. It's very upsetting to other people."[173]

Patients arriving with emergency medical services (EMS) personnel or police officers may be triaged before others. However, they are triaged in the same way as other patients. They are not put in special categories or given a higher category than any other patient of similar acuity. Their quicker access to triage does not give them any priority over other patients in seeing a physician. Getting these patients triaged as quickly as possible simply frees up police officers and EMS staff to return to duty.[174] Injured police, EMS and other emergency personnel may themselves be given priority in getting access to triage and treatment over comparable cases, but not more critical cases, for the same reason.[175]

In some situations, emergency patients may be placed in an area separate from the main waiting room. These may be mentally ill patients, those with a contagious condition or those who pose a security risk, such as criminals. They may also be individuals whose identity needs to be kept confidential, such as victims of domestic violence, or those who are highly recognizable such as celebrities, athletes or politicians.

None of the witnesses provided any example of improper preferential access. This is explained in part by how the triage system operates. The system requires charts to be prepared with notes about the CTAS priority level. Attempts to give improper preferential access would be very evident from the charts. Because of the triage system, people cannot easily jump the queue. As Ms. Taylor said, "So you see it, and that's why people don't do it."[176]

Another reason why improper preferential access does not occur in emergency rooms is a form of internal policing, as described by Mr. Donald Christensen, area manager at the Sheldon Chumir Urgent Care

[173] Testimony of Kathy Taylor, Transcripts, vol. 8, December 6, 2012, at 511.
[174] Testimony of Donald Christensen, Transcripts, vol. 8, December 10, 2012, at 533-34; testimony of Kyle Cridland, Transcripts, vol. 31, February 19, 2013, at 2507.
[175] Testimony of Sheri Drozda, Transcripts, vol. 5, December 5, 2012, at 342-43; testimony of Kyle Cridland, Transcripts, vol. 31, February 19, 2013, at 2509.
[176] Testimony of Kathy Taylor, Transcripts, vol. 8, December 6, 2012, at 512.

Centre in Calgary. If the physician wants to "cherry pick" and put through a lot of patients in a hurry, the nurses very quickly put an end to this. They are very good at saying that this cannot be done and that physicians must see patients according to their CTAS priority. As well, if nurses are trying to speed up the physician, the physicians are very good at saying that they will only take care of one person at a time. Mr. Christensen described this as a sort of policing between professional groups.[177]

Ms. Taylor described a 2012 incident to illustrate how, as she said, decisions are based on the need for treatment, not other influences. Ms. Taylor came into work that morning and found a prominent politician waiting for a bed. She said, "He waited overnight in emergency. So if he was going to get preferential treatment, he would have actually been the first person to get a bed, but he just waited in his line." This person was given confidentiality, meaning his name would not have been put on the REDIS system for others to see. The curtains were pulled so that others walking by would not see him "because he was a very recognizable person."[178]

Ms. Taylor explained that REDIS is the database that sorts patients coming in, and tells staff the patients' priority and the pathway for their treatment. The politician's condition warranted admission and he was hospitalized for a few days. With no bed available, the politician stayed overnight in emergency, which Ms. Taylor said "isn't always the best [place] because we don't turn off the lights and we don't slow down."[179]

Ms. Taylor also testified that she has never received preferential treatment when injured or sick. She said that in January 2012 she fell and tore a ligament, went to triage and was treated like any other patient. She could think of only one incident during her years as an emergency department nurse where somebody was seen or treated more quickly than they should have been. A patient had been taken off a flight and had to be seen quickly to get back on the flight.[180]

Ms. Jill Woodward, the executive director at the Alberta Children's Hospital, described an incident in 2010 where a nurse attempted to get

[177] Testimony of Donald Christensen, Transcripts, vol. 8, December 10, 2012, at 546-47.
[178] Testimony of Kathy Taylor, Transcripts, vol. 8, December 6, 2012, at 506-07.
[179] Testimony of Kathy Taylor, Transcripts, vol. 8, December 6, 2012, at 507-08.
[180] Testimony of Kathy Taylor, Transcripts, vol. 8, December 6, 2012, at 508 and 517-19.

preferential treatment for her child at the emergency department. The nurse insisted that her child be seen before any of the other children in the waiting room because she was a nurse at that hospital. The triage nurse gave the appropriate CTAS score to the patient and the patient was seen in the normal manner. The nurse in question was "spoken to." She later apologized and acknowledged that her behaviour was unacceptable.[181]

Inquiry findings

The evidence before the inquiry consistently showed that procedures used in emergency departments – and, indeed, the professional culture of emergency personnel – serve to limit the potential for improper preferential access. The instances described in which some patients seem to have been attended to more quickly than they appeared to warrant were in fact justifiable on a practical and ethical basis. There was no evidence that giving priority to the patients involved in these incidents delayed the assessment or treatment of any other emergency patient.

In conclusion, I found no evidence, from the admittedly limited testimony before the inquiry on this subject, that improper preferential access is occurring in emergency departments in Alberta.

7. *The private patient path*

Emergency departments were implicated in another potential type of improper preferential access – a phenomenon known as the private patient path. This refers to patients who have been directed to the emergency department by their physician for the purpose of seeing that physician or another specific physician.

One variant of this practice was described by Dr. Brian Holroyd, a practising emergency physician at the University of Alberta Hospital and one of the leaders of a strategic planning group formed by AHS for emergency services in Alberta. He spoke about what he called a direct patient – a patient typically under the care of a specialist at the hospital and who needs care urgently. The specialist would tell the patient to come to the emergency department. The specialist would alert the department that the patient was coming. The patient would be triaged by the emergency department staff on arrival but would not be placed in

[181] Testimony of Jill Woodward, Transcripts, vol. 16, January 9, 2013, at 1273-74.

the same queue for treatment as other emergency patients. Instead, the specialist would come to the emergency department to assess the patient.[182]

Mr. Kyle Cridland, an emergency room nurse at the Foothills Hospital, gave another example of the private patient path phenomenon. Patients would arrive at the emergency department with a letter from their doctor. The emergency room (ER) nurse would call the doctor to attend to the patient in the emergency department. The patient would be assessed by the triage nurse but not put in a queue to see an emergency physician. Instead, the patient would be designated a private patient. Mr. Cridland explained the procedure for handling private patients:

> [G]enerally speaking, a communication has been made from the primary health doctor to the specialist doctor. So they're expecting the patient and they'll usually send a letter in just so that we're aware of what's happening and which doctor to call and that kind of thing…. [A]t the Foothills we have two rooms in the waiting room that have stretchers in them [in which] physicians can assess patients. So they're used mainly for the private patients that come in so that they don't take up actual beds inside our department.[183]

Mr. Cridland also testified that "every now and then" another patient would see this treatment of private patients and become upset. He would usually tell them the truth and explain that the private patient was there to see a doctor and "everyone is here for different reasons. Some people are here to see certain doctors. Some people are here to see emergency doctors. I just kind of explain to them what's going on, with no specific patient details, obviously."[184]

Ms. Sheri Drozda, a nurse clinician, explained the private patient path as involving private patients who come from various places – perhaps a clinic on another floor of the hospital – where they have been assessed and deemed to need admission. Sometimes patients seeing a particular specialist will be told to meet the doctor at triage. The triage nurse usually gives that doctor a call to confirm that the doctor is expecting the patient. Once this is confirmed, the triage nurse checks in the

[182] Testimony of Brian Holroyd, Transcripts, vol. 6, December 5, 2012, at 404-05.
[183] Testimony of Kyle Cridland, Transcripts, vol. 31, February 19, 2013, at 2501.
[184] Testimony of Kyle Cridland, Transcripts, vol. 31, February 19, 2013, at 2502.

patient and makes an emergency department treatment chart, but for treatment as a private patient. These patients are triaged under the CTAS system but they are not put in any sort of priority. They are labelled a private patient, according to Ms. Drozda. Still, she said, they are considered emergency department patients to be looked after by ER staff. The physician they see will use ER resources such as ER examination rooms, and these private patients will be admitted or discharged through the ER.[185]

While this appears to be an accepted practice among ER staff and physicians, the inquiry also heard evidence about how some similar practices were not considered acceptable. For example, Mr. Donald Christensen described how one physician at the Sheldon Chumir Urgent Care Centre attempted to fast-track patients from his outside clinic. The physician was working in urgent care and had told clients to come to urgent care to see him. They were told to speak to the triage nurse and tell the nurse to send them back to the physician. The triage nurse blocked this.[186] Similarly, Ms. Kathy Taylor described how a physician routinely told his surgical patients to meet him at the Peter Lougheed Centre's emergency department for lap band adjustment procedures following weight surgery. She considered this an inappropriate use of emergency department resources, and told the physician so.[187]

Inquiry findings

It is certainly not clear from the evidence I heard as to when the private patient path is acceptable and when it constitutes improper preferential access. It is also not clear why it is necessary or desirable to have a system involving a private patient path. There was no evidence of any policy, either system-wide or a local policy within a facility, to address this practice.

The final submissions on behalf of AHS argued that this practice may more accurately be described as "situations where community and specialist physicians with privileges to admit and treat their patients in a hospital, arrange to assess personal patients with urgent needs in the [emergency department] at times when they cannot do so in their

[185] Testimony of Sheri Drozda, Transcripts, vol. 5, December 5, 2012, at 338-39.
[186] Testimony of Donald Christensen, Transcripts, vol. 8, December 6, 2012, at 545.
[187] Testimony of Kathy Taylor, Transcripts, vol. 8, December 6, 2012, at 519.

community offices or hospital-based clinics."[188] That is one way of looking at it. It may also simply be convenient for the physicians. I can understand how it may sometimes be an effective way to manage a high volume practice. One of our expert witnesses, Ms. Pamela Whitnack, referred to it by focusing on the situation in rural Alberta:

> In many cases in rural Alberta, you have a very small physician base in a particular community. For these individuals to function in a practice and maintain service in an (emergency room) and in an outpatient area and so on, it's very difficult/taxing on their time, and it's a matter, perhaps, of some convenience. I would not ever mean to suggest that the people that they would have meet them in emergency don't have clinical urgency. It is just simply a matter of perhaps the best way to organize, dealing with the volume of patients and the volume of service that's required in that particular area, and they're professionals doing their best to treat the people that need to be seen.[189]

As with several other situations examined in this report, one cannot draw definitive conclusions without knowing the context in which the issue arises. If a procedure or assessment is not urgently needed, it would be improper preferential access to arrange for a patient to go to the emergency department to receive it sooner than if the patient attended the physician's office. On the other hand, if a patient requires services but cannot reasonably obtain those services through scheduling an appointment at a physician's office or specialist clinic, it may be necessary to obtain those services through the emergency department. Both cases involve a potential misuse of emergency resources and demonstrate a lack of coordination of services in the health care system.

An in-depth analysis of the benefits and drawbacks of the private patient path phenomenon would be useful. That analysis must go beyond simply examining procedures and include the ethical implications of the private patient path. I have no doubt that personnel working in emergency departments, as well as physicians and nurses in general, would benefit from having clear protocols.

[188] Closing Submissions of Alberta Health Services, April 1, 2013, at 14 (Exhibit 164).
[189] Testimony of Pamela Whitnack, Transcripts, vol. 38, February 26, 2013, at 3279-80.

Recommendation 10:

Develop policies for the private patient path

Alberta Health Services, in consultation with appropriate stakeholders, should analyze the ethical and practical implications of the private patient path and develop appropriate policies for emergency department personnel and physicians.

8. *The Colon Cancer Screening Centre*

The inquiry heard testimony from 15 witnesses over several days about the alleged preferential treatment of some patients at the Colon Cancer Screening Centre (CCSC), also known as the Forzani & MacPhail Clinic. The CCSC opened in 2008. It was established to enable screening colonoscopies to be moved out of acute care facilities. Screening colonoscopies are those done, for example, when a person reaches a threshold age, even if the person has no symptoms suggesting the need for a colonoscopy. Acute care facilities such as the University of Calgary Medical Clinics (UCMC) would then be freed up to handle colonoscopies for patients who were symptomatic – for example, those with gastrointestinal symptoms or bleeding. As well, the CCSC established a central triage process, leading to a common queue in the Calgary region for screening colonoscopies. The inquiry heard evidence about several incidents relating to the CCSC that might constitute improper preferential access:

- that some patients from a private executive medical clinic, Helios Wellness Centre, were allegedly obtaining much faster access to screening colonoscopies at the CCSC than the norm;
- that one physician in particular was allegedly instrumental in achieving this;
- that some of that physician's other patients were allegedly receiving preferential access;
- that membership in Helios was allegedly intended to reward donors to the University of Calgary, possibly by facilitating preferential access; and

- that the CCSC clinic manager may have had a special relationship with Helios that could have enhanced access by Helios patients to the CCSC or that could give the impression of favouritism.

All participants in the inquiry found the evidence on this topic complex and at times difficult to grasp. Nevertheless, patterns of behaviour emerged, clearly demonstrating that procedures instituted at CCSC for arranging colonoscopies were circumvented for certain patients. This enabled them to bypass the normally long waiting periods faced by those in the common queue.

a) *Establishment of the CCSC*

The CCSC sought to bring all asymptomatic patients under one roof for screening colonoscopies. The CCSC was intended to provide family physicians a way to refer patients for colonoscopies directly, without sending them to individual specialists. It was also intended to facilitate a common queue for screening colonoscopies. Having screening colonoscopies handled through the CCSC would also free up hospital space for those who truly needed it, such as patients who were symptomatic.

The CCSC was initially operated by the University of Calgary under contract with the Calgary Health Region. In 2010, administration was transferred from the University to AHS.

When the CCSC first opened, it took over the University of Calgary Medical Clinics (UCMC) gastroenterology wait list for routine screening. That list contained approximately 15,000 names. In addition, every day after it opened, the CCSC received about 200 new referrals.[190] Ms. Darlene Pontifex, manager of the CCSC since its beginning, described the files inherited from UCMC as a "clerical nightmare." They were out of order and simply stacked in filing cabinets.[191]

Ms. Pontifex testified that, in its early days, the CCSC had difficulty filling its endoscopy slots (available appointment times) despite this backlog. The clinic did not have sufficient clerical staff and the nurses,

[190] Testimony of Alaa Rostom, Transcripts, vol. 26, January 16, 2013, at 2025 and 2029-2030; testimony of Darlene Pontifex, Transcripts, vol. 33, February 20, 2013, at 2717-18.
[191] Testimony of Darlene Pontifex, Transcripts, vol. 33, February 20, 2013, at 2717-18.

who were new to gastroenterology, were taking a long time – up to an hour – for screening consultations with patients. For that reason, the CCSC clinic was unable to book all the endoscopy slots. In addition, patient information from some UCMC files was inaccurate. Phone numbers had changed and addresses were wrong. Mailing appointment times to patients worked, but was very labour intensive.[192]

b) *The process at the CCSC*

The CCSC adopted a formal policy for referrals early on. The policy is contained in a document entitled Colon Cancer Screening Centre – Referral, Triage and Pre-Assessment.[193] The effective date of the policy was October 31, 2007, and its latest revision is dated August 3, 2012. The policy was in place when the CCSC opened.[194]

The process for colonoscopies at the CCSC begins with a physician – typically a family physician – sending a referral, a standardized form requesting a colonoscopy. Referrals are sent to CCSC by fax. A triage clerk reviews them. The triage clerk takes referrals requesting screening for an average risk patient directly to another clerk who makes a data entry and files them. Anything involving a referral other than routine average risk is reviewed by the triage clerk. If the form is incomplete, the clerk returns it to the physician for the required information. The clerk gives the properly completed referral to the triage nurse who assesses it as average risk, moderate, urgent or urgent priority. Then they are given to the booking clerks. The booking clerks then contact the patient to set up a pre-screen – the appointment that precedes the actual colonoscopy – at the clinic.[195]

The wait to obtain a pre-screen in moderate or urgent cases is less than eight weeks. Routine cases take much longer, more than 18 months.[196] Routine cases go into a filing cabinet in chronological order according to the date they were received. When booking pre-screens for routine referrals, the CCSC takes the oldest referrals first.

Referrals triaged as urgent and moderate are given directly to a clerk to be booked for the next available pre-screen. Once the urgent and

[192] Testimony of Darlene Pontifex, Transcripts, vol. 33, February 20, 2013, at 2723-24.
[193] Exhibit 105.
[194] Testimony of Alaa Rostom, Transcripts, vol. 26, January 16, 2013 at 2050.
[195] Testimony of Darlene Pontifex, Transcripts, vol. 33, February 20, 2013, at 2732-33.
[196] Testimony of Darlene Pontifex, Transcripts, vol. 33, February 20, 2013, at 2733.

moderate cases are booked, clerks at the CCSC turn to the routine referrals that are filed in chronological order in the filing cabinets.[197]

At the pre-screen, the colonoscopy procedure is explained and a nurse obtains medical information from the patient. Patients then go to the front desk and book the actual colonoscopy procedure. The procedure normally takes place from two weeks to a few months after the pre-screen.[198] There are 40 to 45 endoscopists – it varies over time – on the clinic roster performing colonoscopies.

The CCSC medical director, Dr. Alaa Rostom, testified that priority was always given to the moderate, urgent, and urgent priority categories. On any given day, slots would be filled first with those patients. Remaining slots would be used for routine patients, who would be scheduled based on the time they had spent on the referral list.[199] Dr. Rostom stated that the clinic never discouraged a patient from seeing a particular endoscopist, but that the referral form said something to the effect that a patient choosing a specific physician might wait longer for the procedure.[200] He agreed with counsel's suggestion that it was certainly never intended that clients could achieve a shorter waiting time by choosing their own endoscopist.[201]

When the CCSC first opened, endoscopists were allowed to book patients who were on their own wait lists. This meant that they were allowed to bring their own patients to the CCSC for colonoscopy procedures while at the same time doing procedures on patients from the CCSC wait list. Dr. Rostom explained that this initial practice was viewed as "a fair compromise ... because these people [endoscopists] had their own backlog, that we would say, 'Look, you do four patients from our backlog list and then you can bring four patients from your own.'[202] Normally, procedures are grouped by lists. A list is a half day of procedures – a total of eight, given that each procedure normally

[197] Testimony of Dayna Sutherland, Transcripts, vol. 23, January 15, 2013, at 1884-86.
[198] Testimony of David Beninger, vol. 23, January 15, 2013, at 1837-38; testimony of Darlene Pontifex, Transcripts, vol. 33, February 20, 2013, at 2734.
[199] Testimony of Alaa Rostom, Transcripts, vol. 26, January 16, 2013 at 2075.
[200] Testimony of Alaa Rostom, Transcripts, vol. 26, January 16, 2013, at 2076. Two versions of the referral form, Exhibit 90 and 92, say nothing about a longer wait time in the situation Dr. Rostom described. However, Dr. Rostom may have been referring to Exhibit 93, also a referral form, which contains wording about possibly longer wait times for patients who request to see a particular gastroenterologist.
[201] Testimony of Alaa Rostom, Transcripts, vol. 26, January 16, 2013, at 2077.
[202] Testimony of Alaa Rostom, Transcripts, vol. 26, January 16, 2013, at 2055.

takes half an hour. Endoscopists who did a list could therefore perform four procedures on their own patients and four from the CCSC list. If the endoscopists did two lists – a full day of procedures – they could perform eight procedures on their own patients. Dr. Rostom said that these endoscopists would have triaged their own lists and that the clinic accepted their decisions about triage.[203]

The inquiry heard evidence about operational difficulties encountered by CCSC in its first year or so. There was a shortage of clerical staff and an insufficient and faulty technological infrastructure to process the volume of referrals. As noted earlier, referrals on the UCMC wait list the clinic inherited often contained incorrect patient contact details. As a result, the CCSC could not locate the patients from these inherited referrals to fill all the available appointment slots. The clinic resorted to filling these slots with private patients or more recent referrals whose contact information was up to date. Still, Ms. Pontifex emphasized in her testimony that the goal was to organize the CCSC list so that patients were seen according to level of urgency and date of referral.[204]

The purpose behind allowing endoscopists to book their private patients was to get them involved with the CCSC. However, this concession was meant to be temporary. In August 2009 the CCSC adopted a policy to end this practice. The policy, entitled Endoscopist Responsibilities at the Centre, stated that the colonoscopy procedure slots do not belong to individual endoscopists and that the clinic will distribute the slots to best fulfill its mandate. It also contained the following provision:

> Endoscopists can refer their private patients to the centre. However, these patients will be triaged and prioritized along with the rest of the referred patients. Patients have the option to select an individual endoscopist, but doing so may result in a longer wait time. Endoscopists cannot directly schedule patients from their office into CCSC slots.

Dr. Rostom said that in 2010 the clinic stopped allowing endoscopists to bring in patients from their private lists. He gave two reasons. First, the governing view was that there should be a common queue for colonoscopies. Second, the process had become administratively unwieldy. This policy change was achieved gradually, mostly through

[203] Testimony of Alaa Rostom, Transcripts, vol. 26, January 16, 2013, at 2056 and 2058.
[204] Testimony of Darlene Pontifex, Transcripts, vol. 33, February 20, 2013, at 2720.

educating family physicians to use the CCSC referral form so that cases could be triaged appropriately at the CCSC.[205]

c) *Allegations of queue-jumping*

On March 19, 2012, Dr. Rostom sent an email to several recipients. Entitled "Concerns over Endoscopy Queue-Jumping – CCSC policy on the subject,"[206] the email expressed concern that queue-jumping could occur if endoscopists tried to book private patients onto their CCSC lists. The email stated, in part:

> Recently the issue of "Queue jumping" has taken prominence with government and AHS. I want to take a moment to reiterate CCSC policy on the subject....
>
> "Queue jumping" is a broad term which can encompass legitimate reasons for advancing a patient's appointment for medical reasons, as well as cases for which the reasons are not medically related.
>
> ...
>
> It is acknowledged that all examples of "queue jumping" are a very small percentage of the volume handled at CCSC.
>
> I would however like to explicitly state CCSC policy on endoscopist initiated "queue jumping" – which can occur, for example, if endoscopists try to book private patients in their CCSC lists. In this context, private patients mean patients that have been referred to; or are known to; an endoscopist who historically would have been scoped by the endoscopist at their acute care sites prior to opening of CCSC.
>
> CCSC policy for the last few years has been that CCSC cannot take patients for direct booking with the requesting endoscopist.
>
> The following policy statement indicates CCSC protocol on this issue:

[205] Testimony of Alaa Rostom, Transcripts, vol. 26, January 16, 2013, at 2060-61.
[206] Exhibit 109.

1. CCSC cannot accept endoscopists' private patients to be booked directly with that endoscopist.
2. CCSC endoscopists can refer private patients to CCSC if:
 a. the endoscopist fills out a standard CCSC referral;
 b. the referral is sent to CCSC triage (not a booking clerk);
 c. the endoscopist acknowledges that the referral will be triaged with the rest of the CCSC referrals and given a priority based on our triage policy;
 d. the endoscopist acknowledges that the patient may not be booked with the requesting endoscopist.
3. The preferred route for referral to CCSC is for the endoscopist to ask the referring family physician to refer the patient to CCSC directly (as we do with referrals to central GI triage).

It is critical that all CCSC endoscopists and staff follow this policy. There may be extraneous or unexpected circumstances that we have not covered by this policy. If you have such examples, please let me know so it can be incorporated into the policy statements.

Dr. Rostom said that, shortly before he wrote his email, he had received a telephone call from Ms. Barbara Kathol, one of the executive directors at the Foothills Hospital. She told him of rumours that Dr. Ronald Bridges was directly booking patients at the CCSC.[207] She was in effect telling him that Dr. Bridges was booking patients through a booking clerk rather than putting the referrals through the CCSC central triage process.[208]

Dr. Ronald Bridges is a gastroenterologist as well as the senior associate dean of the University of Calgary Faculty of Medicine. He was instrumental in preparing the original plan for the establishment of CCSC and played a prominent role in its early development. He was the CCSC medical director from its founding until early 2008. He was described by Ms. Pontifex as a founder of CCSC and by another

[207] Testimony of Alaa Rostom, Transcripts, vol. 26, January 16, 2013, at 2119-20.
[208] Testimony of Alaa Rostom, Transcripts, vol. 26, January 16, 2013, at 2140-41; testimony of Barbara Joan Kathol, Transcripts, vol. 30, January 18, 2013, at 2429.

physician as its "de facto director."[209] He was and is by all accounts a highly influential leader in the Calgary medical community.

Some of the allegations relating to Dr. Bridges involve a private medical clinic that some might describe as an executive medical clinic. This is the Helios Wellness Centre. Helios was founded in 2007 by Dr. T. Chen Fong. It is a medical clinic that provides both insured and non-insured services, such as massage and physiotherapy, diet counselling, exercise testing and yoga. Insured services are provided by physicians on staff who bill AHS for those services. The Centre charges a fee of $10,000 per year for a single adult membership, $15,000 for a couple, and $3,000 for dependents. The fee is said to cover the non-insured services provided at the Centre. There are currently 260 memberships covering 700 people.[210] Helios, according to its founder, is a not-for-profit organization, although it is not a registered charity. Dr. Fong stated that he established it to fund a fellowship program at the University of Calgary Faculty of Medicine.[211] At a leadership forum meeting at the Faculty of Medicine on April 2, 2012, Helios was described as "a corporate centre [started] to provide a relationship between the downtown community and the University of Calgary."[212] Dr. Bridges was not on staff at Helios, but he and Dr. Fong have known each other for many years.

Ms. Kathol was prompted to call Dr. Rostom by information she received in March 2012 from Dr. Jonathan Love, the gastroenterology site chief at Foothills Medical Centre and one of the endoscopists who performed colonoscopy procedures at CCSC. He had told her that preferential access to colonoscopy care was continuing at CCSC even though there was a centralized triage system.[213] I say "continuing" because Dr. Love had raised the same concern with Ms. Kathol in early 2011 after he had noticed discrepancies in how Dr. Bridges' patients were booked. He also brought to her attention a delivery of wine at Christmas 2010 to CCSC as a gift from the Helios management. Both

[209] Testimony of Darlene Pontifex, Transcripts, vol. 33, February 20, 2013, at 2714; testimony of Mark Gordon Swain, Transcripts, vol. 29, January 18, 2013, at 2398.
[210] Testimony of Leah Dawn Tschritter-Pawluk, Transcripts, vol. 31, February 19, 2013, at 2524; testimony of Douglas Caine, Transcripts, vol. 31, February 19, 2013, at 2565-66; testimony of T. Chen Fong, Transcripts, vol. 32, February 19, 2013, at 2665-66 and 2671.
[211] Testimony of T. Chen Fong, Transcripts, vol. 32, February 19, 2013, at 2658-62.
[212] Exhibit 146.
[213] There was evidence that Ms. Kathol was also alerted by Dr. Mark Swain in March 2012 about a physician maintaining a private list at CCSC: see testimony of Mark Gordon Swain, Transcripts, vol. 29, January 18, 2013, at 2390-91.

he and Ms. Kathol thought that was highly unusual and inappropriate.[214]

Dr. Love testified that he had experienced an earlier discrepancy regarding the treatment of a Helios patient referred to Dr. Bridges at the UCMC endoscopy clinic. The patient was booked to see Dr. Love since he was available and he examined the patient on November 1, 2010. Dr. Love noted that the patient's chart was marked as "urgent priority," but the examination revealed that the patient did not fit that triage designation. He said that the patient was moderate risk by any criteria.[215] He was disturbed by this because the referral letter was dated Friday, October 28, and the patient was booked and seen just a few days later, on Monday, November 1. Ordinarily, the wait for a moderate risk patient to have a consultation was 10 months.[216]

I mention this only because it illustrates in part what motivated Dr. Love to raise the issue with Ms. Kathol in the first place. I recognize that physicians may differ about the appropriate triage status of a patient. This patient's family physician may see a condition as being an urgent priority while another physician may conclude the risk merely to be moderate. It is undisputed, however, that the consultation was booked and the patient was seen for a consultation within three days of receipt of the referral letter.

Ms. Kathol testified that she spoke to Dr. Rostom when Dr. Love first raised his concerns in early 2011. She told Dr. Rostom about the rumour connecting Dr. Bridges and patients of the Helios Centre being booked in advance of the queue. However, according to Ms. Kathol, Dr. Rostom was adamant that there was no improper preferential access occurring at CCSC.[217]

Ms. Kathol said that her conversation with Dr. Rostom in 2012 took place on Friday, March 16. Dr. Rostom was going to look into the rumours and tell her what he had found. He did not get back to her. Instead, the following Monday (March 19), he distributed the email

[214] Testimony of Barbara Kathol, Transcripts, vol. 30, January 18, 2013, at 2430-33; testimony of Jonathan Richard Love, Transcripts, vol. 30, January 18, 2013, at 2453-54 and 2460.
[215] Testimony of Jonathan Richard Love, Transcripts, vol. 30, January 18, 2013, at 2448.
[216] Testimony of Jonathan Richard Love, Transcripts, vol. 30, January 18, 2013, at 2444-48.
[217] Testimony of Barbara Kathol, Transcripts, vol. 30, January 18, 2013, at 2429-30.

cited earlier. Ms. Kathol concluded that Dr. Rostom clearly articulated the CCSC policy in the email and, whether the rumours of queue-jumping were true or not, the email should have put an end to the matter.[218]

Dr. Francois Belanger, senior vice-president and Calgary zone medical director for AHS, first saw the Rostom email on March 19, 2012. He then spoke with several people, including Ms. Kathol, Dr. Rostom and Dr. Mark Swain, head of the gastroenterology division at the University of Calgary, to get an understanding of the issue. Dr. Belanger testified that his impression, after these discussions, was that charts coming primarily from the Helios Wellness Centre were being flagged and ended up on a private booking list for Dr. Bridges. The concern was that these patients would be seen ahead of others. He understood from Dr. Swain that this rumoured queue-jumping had been going on for a period of time, possibly years.[219]

Dr. Belanger asked Dr. Rostom whether a further review of queue-jumping was needed. Dr. Rostom replied that if there were any irregularities, they had already been fixed and there were no further issues. Dr. Belanger said he was reassured by Dr. Rostom's statement and by Dr. Rostom's email, which Belanger said clearly stated the procedure and the expectations for physicians in terms of booking.[220]

Dr. Belanger spoke with colleagues about whether a further review of the process and of the actions of any particular physician was needed. He discussed this with his superiors at the time, Dr. David Megran and Dr. Chris Eagle. After this discussion, he felt assured that irregularities had been fixed and that there was now a clear policy for physicians.[221]

Dr. Belanger acknowledged that he did not speak with Dr. Bridges or look at any patient charts for evidence relating to the concerns raised by the Rostom email. Dr. Belanger said that to investigate under the AHS bylaws, he would need stronger evidence – someone coming forward, putting their name on a document and agreeing to have their identity disclosed. He said he could investigate without this evidence, and so

[218] Testimony of Barbara Kathol, Transcripts, vol. 30, January 18, 2013, at 2435-37.
[219] Testimony of Francois Paul Belanger, Transcripts, vol. 26, January 16, 2013, at 2154, 2159-61 and 2166-67.
[220] Testimony of Francois Paul Belanger, Transcripts, vol. 26, January 16, 2013, at 2167-72.
[221] Testimony of Francois Paul Belanger, Transcripts, vol. 26, January 16, 2013, at 2172.

could AHS, but they would still need something of substance to proceed. Dr. Belanger stated that he respected Dr. Rostom's judgment and that, besides, he could not substantiate any information elsewhere.[222]

d) *Evidence of improper preferential access*

Witnesses gave a significant volume of testimony demonstrating that patients of Dr. Bridges or of the Helios Wellness Centre received much faster appointments for screening procedures at CCSC than was the norm. Documents filed with the inquiry supported this conclusion.

From the CCSC's opening in 2008 to 2012, the typical wait time in a routine referral for a pre-screening appointment was two to three years.[223] Today the wait time for routine cases is "greater than 18 months."[224] The evidence revealed that many patients referred to Dr. Bridges or those who were clients of the Helios Wellness Centre received pre-screening appointments within weeks, and often days, of CCSC receiving a referral. This occurred over a period of several years – at least until late 2011.

CCSC records filed with the inquiry show that in most cases the entries for these patients were marked "urgent priority," even when the original referral form had identified their case as routine. These entries noted explicitly that the individual involved was a "Helios patient" or a "Dr. Bridges patient."[225]

Several witnesses gave evidence about the procedures for booking these patients. The Helios clinic manager spoke about how referrals would be hand-delivered to CCSC in its early days (something that was easy to do because the Helios Centre is in the same university building as the CCSC). Then Helios started faxing the referrals but, because of administrative difficulties within CCSC that resulted in some referrals being lost, Helios management decided to email the referrals. The emails were sent to Ms. Pontifex, the CCSC manager, with a copy to

[222] Testimony of Francois Paul Belanger, Transcripts, vol. 26, January 16, 2013, at 2173-75.
[223] Testimony of Samantha Jane Mallyon, Transcripts, vol. 24, January 15, 2013 at 1946; testimony of Dayna Sutherland, Transcripts, vol. 23, January 15, 2013, at 1887; testimony of David Beninger, Transcripts, vol. 23, January 15, 2013, at 1839; testimony of Darlene Pontifex, Transcripts, vol. 33, February 20, 2013, at 2720.
[224] Testimony of Darlene Pontifex, Transcripts, vol. 33, February 20, 2013, at 2733.
[225] See Exhibits 91-101.

Dr. Bridges. Sometimes they were sent to Dr. Bridges directly, with a copy to Ms. Pontifex.[226] It was acknowledged at the inquiry that Ms. Pontifex was a patient of one of the doctors who worked at the Helios Centre, although she did not pay the fee charged ordinarily since she did not access any of the clinic's non-insured services.

There was evidence as well that Dr. Bridges would email requests for screening colonoscopies directly to Ms. Pontifex and an administrative assistant at CCSC.[227] The assistant testified that she would receive these emails and, even though this was not the normal booking procedure and her job did not involve booking patients, she would book them anyway. She said she did this "out of respect" for Dr. Bridges.[228]

These bookings were either for Helios patients or for those patients that Dr. Bridges would attend to personally; in other words, they were on a list dedicated specifically to Dr. Bridges.

Several individuals who served as clerks at CCSC also testified about Helios patient referrals. These referrals would come to the clerks specially marked as either Helios patients or Dr. Bridges' private patients. The referrals were consistently treated as an urgent priority. They said they knew this was not the normal booking procedure, but this was the practice regarding these referrals. They also said they were directed to do this by Ms. Pontifex.[229]

Dr. Rostom was asked about evidence that the clerks had standing instructions from Ms. Pontifex to book Helios patients as urgent cases. He said, "There was no direction given on that. And I would also say that I work very closely with Darlene Pontifex, and I can't imagine that she has any direction that would have said that either."[230]

Ms. Pontifex also testified about these allegations. She stated that until the practice ended in 2010, Helios patients were given the same treatment for bookings as private patients in that they had their own

[226] Testimony of Leah Dawn Tschritter-Pawluk, Transcripts, vol. 31, February 19, 2013, at 2526-28 and 2532.
[227] See Exhibits 131-133 and 145.
[228] Testimony of Olga Koch, Transcripts, vol. 35, February 25, 2013, at 2892-94.
[229] Testimony of Dayna Sutherland, Transcripts, vol. 23, January 15, 2013, at 1887-90; testimony of Dayna Sutherland, Transcripts, vol. 24, January 15, 2013, at 1937-38; testimony of Samantha Jane Mallyon, Transcripts, vol. 24, January 15, 2013, at 1946-50.
[230] Testimony of Alaa Rostom, Transcripts, vol. 26, January 16, 2013, at 2097-98.

booking folder and they were booked in faster than those on the regular waiting list. She said:

> But it was a problem for us ... for booking patients because the information we had was so outdated on our referrals from UCMC, that that's where the private patients from the physicians came in handy because they were up to date with their phone numbers and addresses. And that's the same thing with Helios patients. They were up to date and easy to contact.[231]

Ms. Pontifex claimed that Helios patients were treated in this manner to help CCSC fill its endoscopy spaces. Helios patients were booked into regular slots that had not been filled. However, Ms. Pontifex could not recall any other private or public clinic receiving similar treatment. She said no one at CCSC had ever approached other clinics to get patients.[232] The question of whether Ms. Pontifex was influenced in filling these available slots with Helios patients because she was herself a patient at Helios (albeit not a fee-paying one) was not explored at the hearing.

But all this, Ms. Pontifex said, occurred when CCSC was still taking private referrals from endoscopists. She maintained that this practice stopped in 2010 when CCSC switched completely to its standard booking procedure. She claimed to be unaware of the email traffic between Helios and Dr. Bridges (because she did not read her emails, she explained) and was unaware that Dr. Bridges was giving referrals directly to the administrative assistant. When confronted with the evidence, Ms. Pontifex had to acknowledge that this practice of preferential treatment for certain patients had not been discontinued as she had thought. She confirmed that this was contrary to the expected CCSC booking procedure.[233]

When asked who decided to give priority to the Helios files, with its own folder and its own booking procedure, Ms. Pontifex said that such a directive may have been "implied" by Dr. Bridges. She said that Dr. Bridges had a management role with the CCSC as an advisor, although

[231] Testimony of Darlene Pontifex, Transcripts, vol. 33, February 20, 2013, at 2747.
[232] Testimony of Darlene Pontifex, Transcripts, vol. 33, February 20, 2013, at 2747-48.
[233] Testimony of Darlene Pontifex, Transcripts, vol. 33, February 20, 2013, at 2740-41.

his role was informal. She said she took direction from him because he had this role.[234]

Dr. Bridges was asked to respond to the testimony that the referrals he forwarded to CCSC were to be booked in priority to other patients. He said he did not know CCSC was treating the files this way. He never gave any thought to the possibility that when he – founder of the clinic – handed a referral to someone of lower status, he might be creating an expectation about how the referral was to be handled. He said he "did not appreciate that" at the time. He said that when he gave information to the clinic, he highlighted the high-risk cases to ensure they received priority. He expected that average risk cases would be dealt with like the rest of the referral base.[235]

It should be made clear that we are talking here about a very small number of patients out of the more than 60,000 that have been screened at CCSC since its opening.

Inquiry findings

The evidence satisfies me that, for a significant period of time, some patients identified as Helios patients or Dr. Bridges' private patients received improper preferential access to CCSC screening colonoscopies. The preference consisted in bypassing the lengthy typical waits for routine screenings by deliberately marking these referrals as urgent and booking them for the earliest moment possible. This process violated the established CCSC booking procedures.

Therefore, there was no medical or ethical justification for this preferential treatment.

I am also satisfied that this improper preferential access was facilitated in two ways: (1) by Dr. Bridges giving referrals directly to an administrative assistant or a booking clerk; and (2) by Ms. Pontifex directing booking clerks to give priority to these referrals. They did so, in my opinion, simply because of the status and respect enjoyed by Dr. Bridges.

This evidence illuminates a problem that is not unique to the health care system: people of status or superior position using their authority

[234] Testimony of Darlene Pontifex, Transcripts, vol. 34, February 20, 2013, at 2756-58.
[235] Testimony of Ronald Bridges, Transcripts, vol. 36, February 25, 2013, at 3018-19.

to bypass established systems for the benefit of themselves or their clients; and people in inferior positions doing as they are asked because of that status even when aware that they themselves will not then be following established procedures. This does not require overt intimidation by the superior. All that it requires is an atmosphere where front-line workers are either insufficiently equipped to deal with such demands or do not feel they have the backing of management to stand up to these demands. In this situation, it was apparent to me that the CCSC clerks who testified did not know who to talk to about their questions or concerns regarding Dr. Bridges' booking procedures.

The best way to address these types of issues is to ensure that staff members at every level of the organization are familiar with the organization's procedures and that senior management supports them in applying those procedures.

I want to address two issues that were highlighted in some of the closing submissions. One is why the Helios Centre emailed referrals to Dr. Bridges. Commission counsel submitted that this was a way to circumvent the normal booking process and thus obtain improper preferential access to CCSC screening procedures. The other relates to a submission by Commission counsel that allegations regarding queue-jumping at CCSC were consistently dismissed without investigation.

Why were emails being sent to Dr. Bridges? The Helios lead physician, Dr. Douglas Caine, and its clinic manager, Ms. Leah Tschritter-Pawluk, explained that this was a response to the administrative problems being encountered at CCSC in handling referrals. They hoped that their concerns could be addressed more effectively by involving a physician in the referral process.[236] They considered this action the next step up the chain in raising their concerns.[237]

The system of emailing referrals began in late 2010 and continued until early 2012. Dr. Caine viewed it as a way of advocating for Helios patients in a system that was inefficient. He said, "That's where the email came up." Helios was being told by CCSC to re-fax referrals that CCSC could not locate. "At some point you have to stop re-faxing it and try and find a different way to advocate for your patients so that

[236] Testimony of Leah Dawn Tschritter-Pawluk, Transcripts, vol. 31, February 19, 2013, at 2527-28; testimony of Douglas Caine, Transcripts, vol. 32, February 19, 2013, at 2604.
[237] Testimony of Douglas Caine, Transcripts, vol. 32, February 19, 2013, at 2655-56.

you don't leave them at risk."[238] Also, he stated, "We had a problem. And the problem was that we were sending referrals that were never entered into their database."[239]

As to why the emails were sent specifically to Dr. Bridges, Dr. Caine said that he had been referring patients to Dr. Bridges for gastroenterology consultations for several years. He had a comfortable relationship with Dr. Bridges.[240] And Helios was not alone in emailing Dr. Bridges. As Dr. Bridges testified, "Some people were always emailing with requests and attaching referral notes. It wasn't just Helios. There were physicians throughout the community."[241]

Ms. Tschritter-Pawluk said that in emailing Dr. Bridges, it was "absolutely not" her hope that he would be able to get Helios patients into the CCSC faster. Her hope was to experience less mismanagement and loss of referrals that Helios sent to CCSC.[242] Dr. Caine was asked if he was aware "at any time of any arrangement between Helios and CCSC by which Helios patients, who were at average risk for colorectal cancers, would be scheduled for their pre-screening appointments and/or their colonoscopies in priority to other average-risk patients." Dr. Caine said he was not aware.[243] Dr. Bridges confirmed in his testimony that no one at Helios asked him to obtain preferential treatment for their clients.[244]

I accept that there was no conscious effort by Helios staff and physicians to circumvent CCSC booking practices. Dr. Caine testified that he had no knowledge of the wait times at CCSC[245] and there was no reason for him to make note of how quickly his patients were being seen at CCSC.[246] However, I have no doubt that the emails were sent to Dr. Bridges in part because of his stature at CCSC and the expectation that he would help navigate those referrals through the CCSC system.

[238] Testimony of Douglas Caine, Transcripts, vol. 32, February 19, 2013, at 2607.
[239] Testimony of Douglas Caine, Transcripts, vol. 32, February 19, 2013, at 2610.
[240] Testimony of Douglas Caine, Transcripts, vol. 32, February 19, 2013, at 2608.
[241] Testimony of Ronald Bridges, Transcripts, vol. 36, February 25, 2013, at 3039.
[242] Testimony of Leah Dawn Tschritter-Pawluk, Transcripts, vol. 31, February 19, 2013, at 2533.
[243] Testimony of Douglas Caine, Transcripts, vol. 32, February 19, 2013, at 2612.
[244] Testimony of Ronald Bridges, Transcripts, vol. 36, February 25, 2013, at 3090.
[245] Testimony of Douglas Caine, Transcripts, vol. 32, February 19, 2013, at 2599.
[246] Testimony of Douglas Caine, Transcripts, vol. 32, February 19, 2013, at 2615-16.

The end result, regardless of the motives of the staff and physicians at Helios, is that the referrals sent to Dr. Bridges were booked faster for the reasons I have already outlined. This constituted improper preferential access. The current system of booking procedures at CCSC (not permitting endoscopists to book their private patients without going through CCSC central triage) came into place as early as 2010. If there were problems in the administration of referrals at CCSC, the response should have been for CCSC management to commit to solving those problems, not facilitate ways to circumvent the established triage and booking procedures.

I must also mention another item of evidence that was presented during testimony about the CCSC.

Dr. Mark Swain, the Calgary zone gastroenterology clinical section chief for AHS, testified that the evidence presented to the inquiry about the concerns at CCSC prompted him and Ms. Barbara Kathol to conduct a review of clinic and endoscopy booking practices for all physicians in the gastroenterology division who see patients through the UCMC clinics.[247] The results of that review were entered as exhibits at the inquiry.[248]

Dr. Swain's evidence was that referrals sent to the UCMC are triaged by a triage nurse or a physician based on medical acuity or need and placed with a physician who can see the patient the soonest for that particular triage status. This would occur whether or not the referral was addressed to a particular physician.[249] The review revealed that Dr. Bridges' patients were being booked outside the UCMC central access and triage system, some without the usual referral documents, earlier than other patients. Some of these patients (16 per cent) were clients of the Helios Wellness Centre.[250]

Dr. Bridges testified that, to his knowledge, there was no AHS policy requiring all referrals to UCMC to go through the central access and triage system.[251] He also explained that many of the patient

[247] Testimony of Mark Swain, Transcripts, vol. 35, February 25, 2013, at 2903-05.
[248] Exhibits 140 and 141.
[249] Testimony of Mark Swain, Transcripts, vol. 35, February 25, 2013, at 2951.
[250] Testimony of Mark Swain, Transcripts, vol. 35, February 25, 2013, at 2960-67; Testimony of Mark Swain, Transcripts, vol. 36, February 25, 2013, at 2972-83; Exhibit 141.
[251] Testimony of Ronald Bridges, Transcripts, vol. 36, February 25, 2013, at 3060.

consultations noted in the review were arranged by nurse clinicians and he did not have any direct input into them. Others were procedures for colleagues or involved following up on patients he had seen before. He stated that he never gave his nurse clinicians direction to give preference to Helios patients at UCMC.[252]

It is not for me to draw any firm conclusions about this evidence. The findings of Dr. Swain's and Ms. Kathol's review are, I was told, under further review by AHS. But they do reveal a pattern. Whether deliberately or inadvertently, Dr. Bridges has demonstrated a pattern of circumventing established procedures for triaging and booking procedures for patients at these facilities. This is inappropriate and creates the means to gain improper preferential access.

As noted earlier, Commission counsel submitted that allegations of queue-jumping at CCSC, which she said were raised as early as 2010, were consistently dismissed without investigation. Several items of evidence show that concerns were raised before Dr. Rostom's email of March, 2012.

Dr. Valerie Boswell, a general practitioner who started on contract with CCSC in 2009 to do the pre-screening that preceded the actual colonoscopies, testified that in early 2010 she was seeing a number of Helios patients quite quickly even though they were marked as routine referrals. She raised her concerns at two CCSC administrative meetings, one on March 22, 2010, and another in November 2011. She recalled that Dr. Rostom and Ms. Pontifex were at both meetings. Both times she did not think her concerns were addressed.[253]

As I described earlier, Ms. Kathol testified that she had a conversation in January or February 2011 with Dr. Rostom in which she raised concerns about Dr. Bridges' patients being fast-tracked at CCSC. Dr. Rostom, it must be noted, recalled no such conversation.[254] He said that Ms. Kathol first raised the issue with him on March 16, 2012, which led to his email of March 19. Dr. Rostom may not recall that earlier conversation, but the evidence clearly suggests to me that it took place. The actions of Dr. Love and Ms. Kathol, as described in their evidence, are consistent with this conclusion.

[252] Testimony of Ronald Bridges, Transcripts, vol. 36, February 25, 2013, at 3073.
[253] Testimony of Valerie Boswell, Transcripts, vol. 30, January 18, 2013, at 2475-77 and 2484-85.
[254] Testimony of Alaa Rostom, Transcripts, vol. 26, January 16, 2013, at 2116.

Dr. Rostom testified that after Ms. Kathol raised her concerns with him in March 2012, he did not try to determine if the allegations of preferential access were true. He said he lacked the resources for an extensive investigation and did not investigate on his own. He had received no formal letter of complaint or formal statement on the matter. No matter who was involved, the most appropriate response, he believed, was to send out an email to ensure such conduct would no longer happen.[255]

Dr. Rostom said that he was not sure whether the rumours related only to Dr. Bridges, but that Dr. Bridges was the only individual Ms. Kathol named in their conversation. He did not deny to Ms. Kathol that this conduct was occurring because he felt he had to trust what she was saying. He did not care whether the rumours were true or not because, true or false, he wanted to make the point, through the email, that such conduct was not acceptable.[256]

I cannot accept that Dr. Rostom was unaware prior to 2012 of the allegations that Dr. Bridges' patients and Helios patients were being fast-tracked at CCSC. He may have disregarded those allegations since they were presented only as rumours. Perhaps he may not have wanted to check into them out of deference to Dr. Bridges as his colleague and predecessor. It makes no difference. The point is that there was no investigation undertaken by Dr. Rostom, not after speaking to Ms. Kathol and not before he issued his email of March 19. Indeed, the only investigation to date into these allegations has been the one done by this inquiry.

I accept that Dr. Belanger and his superiors in AHS did not know of these allegations until Dr. Rostom's email. This is likely due to the lack of avenues available for staff to raise concerns to higher levels of authority. There was ample evidence of front-line staff and physicians discussing concerns about queue-jumping among themselves, yet not having any clear idea what the appropriate response would be.

[255] Testimony of Alaa Rostom, Transcripts, vol. 26, January 16, 2013, at 2124-25.
[256] Testimony of Alaa Rostom, Transcripts, vol. 26, January 16, 2013, at 2121-23.

Recommendation 11:

Strengthen access, triage and booking procedures

Alberta Health Services should put measures in place to ensure that:

- access, triage and booking procedures at each Alberta Health Services facility are clearly designated as procedures that must be followed by all medical professionals and staff members;
- staff members are trained about access, triage and booking procedures;
- senior management at each facility is trained on procedures to receive and handle staff concerns regarding non-compliance with procedures by anyone; and
- staff members are aware of the protections available under applicable whistleblower legislation and the procedures for using the legislation.

9. *Executive medical clinics*

The evidence relating to the Helios Wellness Centre raised several issues that are beyond my mandate to examine in detail.

The *Canada Health Act* prohibits both extra-billing by physicians and user charges for any medical and related service that is defined as an insured service within the province's health care insurance plan. However, Albertans can legally pay for certain health services in several situations. The private diagnostic imaging services discussed early in this report is one example. Another example is the private executive medical clinic, or wellness clinic, which, like Helios, offers a range of health-related consultations and non-insured services for a fee. They also offer access to a physician, but those services are charged to the provincial health insurance plan.

The controversy surrounding these types of clinics is whether the membership fee actually constitutes paying for access to a physician. The policy of the College of Physicians & Surgeons of Alberta says that there can be no economic barrier to access to insured medical services. Standards of Practice also speak to accepting patients and

non-discrimination.[257] According to the College's registrar, Dr. Trevor Theman, the direction given to their members who are in such clinics is that access to the physician for primary care medicine must be separate from the basket of uninsured services provided for the fee.[258] In other words, a client should be able to access the physician without having to pay the fee or take up the uninsured services on offer.

In March 2013, Dr. Theman gave an interesting viewpoint on this issue in a College publication:

> In April 2006 – almost 7 years ago – I wrote an article in the Messenger about boutique medical clinics. At the time the issue was the advertising of expedited access for a fee. More recently the issue has simply been one of access, the suggestion that patients who seek access to a family physician at one of these clinics must agree to buy the basket of uninsured services available at many of these clinics.
>
> Typically, this suggestion comes to us as an advertising issue and, as we did in years past, we work with the physicians and the clinics to ensure their advertising is clear that access to a family physician cannot be tied to buying the uninsured services. Otherwise, access would be based on the ability to pay, on socioeconomic status, and that is contrary to ethical principles and to our Standard of Practice on establishing a doctor/patient relationship.
>
> While I am reassured, to a degree, that the clinics with whom we've worked are not barring access based on ability to pay, in part because a significant fraction of the patient population (30% for example) buys none of the uninsured services, I am not completely reassured. Logically, the business could not run if 100% of the family medicine patients opted out of the uninsured services. Is it reasonable to think that the business model and basket of services is so appealing that a majority of enrolled patients want the uninsured services? Or is it more likely that there is a quota in place, a minimum number of patients who must buy the package of services as, otherwise, the cost of providing them would exceed the revenue? I don't

[257] Exhibit 122.
[258] Testimony of Trevor Theman, Transcripts, vol. 29, January 18, 2013, at 2343.

> know the answer, but think we will need to know as we sort our way through this issue.[259]

The inquiry's expert witnesses were asked whether membership-based private health care facilities constitute an example of preferential access and, if so, whether that access is proper or improper. Some of the experts cited such clinics as a means of gaining preferential access, but said that the access was proper. Dr. Goldman wrote that such clinics are proper if limited to non-insured services. However, if membership in the clinic allowed members to contact the physician outside of office hours, and the physician was billing the patient and the province, that would "blur the boundaries between public and private services." It would be highly likely that at some point the patient would be receiving improper preferential access.[260] Dr. Heisler suggested that the practice was consistent with current norms: "Private health care facilities have indicated that the membership fees they charge [are] for 'non-insured' services and not for access to insured services such as physician fees. The membership fee is therefore an example of preferential access to these non-insured services. It is no worse than what currently exists."[261] Dr. Reid wrote that there is nothing to prevent health care professionals from providing services such as physiotherapy, massage therapy, nutritional counselling or chiropractic care. However, Dr. Reid wrote, "Regulatory colleges have typically, and appropriately in my view, clarified that where a funding for a service falls under the *Canada Health Act*, offering access or expedited access to this service based on the payment of a fee is a form of improper preferential access ... a form of extra billing.[262] She continued that the *Canada Health Act* "envisions eliminating financial barriers to access to care by prohibiting physicians from adding extra fees to what they bill the provincial insurer. It does not envision or adequately control for making access conditional on bundling of insured and non-insured services."[263]

Except for Helios, the inquiry heard no evidence about private executive or wellness clinics. There was no evidence about their operations or clientele that would enable me to make any reasonable evaluation for purposes of this inquiry. Certainly these clinics merit

[259] Trevor Theman, "Alberta's Health Services Preferential Access Inquiry," College of Physicians & Surgeons of Alberta, 186 *The Messenger* (March 2013).
[260] Exhibit 149, Expert Reports, report of Dr. Brian Goldman (February 7, 2013) at 18-19.
[261] Exhibit 149, Expert Reports, report of Dr. Owen Heisler (January 2013) at 19.
[262] Exhibit 149, Expert Reports, report of Dr. Lynette Reid (February 15, 2013) at 31.
[263] Exhibit 149, Expert Reports, report of Dr. Lynette Reid (February 15, 2013) at 22.

further analysis. I can think of some obvious issues. Can there be a viable business model for these clinics, as Dr. Theman asks in his article, if patients are able to refuse the fee-based services? If physicians in these clinics limit their number of patients, what strain does this put on the health care system as a whole? Does it limit the supply of primary care physicians for the public at large? Finally, is the College's policy truly enforceable? This inquiry does not have the mandate or evidence before it to address these issues. These are issues best examined by the medical professional associations and the regulators, with public involvement, since it is the public which has the greatest interest in our health care system.

SECTION IV: COMPARISON OF POLICIES ON PREFERENTIAL ACCESS: ALBERTA HEALTH SERVICES, COVENANT HEALTH AND DUCKETT

Earlier, I described the origins of the policy statement entitled Requests for Preferential or Expedited Care prepared at Dr. Stephen Duckett's direction and distributed to senior Alberta Health Services (AHS) personnel on June 11, 2009.[1] I also described how Covenant Health came to adopt a policy of its own, entitled "Accommodating Special Requests."[2] During the inquiry, I also heard evidence from Dr. David Megran that AHS has under consideration a draft policy on improper preferential access.[3]

This section analyzes these three policy documents. An item-by-item comparison is difficult since the policies have different origins, are structured differently and also vary in the level of detail they contain. Even so, it is possible to compare their major tenets. I also offer some commentary on certain aspects of them.

1. *Origins of the policies*

As I explained in the discussion of courtesy or heads-up calls in the previous section, the Covenant Health policy stemmed from actual events. Dr. Gordon Self, now Vice-President of Covenant Health, was intimately involved in drafting the 2007 policy of Caritas that became the Covenant Health policy. He explained that the Caritas policy flowed from the need to respond to a number of instances in which Caritas received a heads-up call from Capital Health. The heads-up would be that "somebody ... like a board member or some other individual of a VIP status, [or] some person of significance in the community would have been in our building, for whatever reason, and they were letting us know and just wanting us to be aware of that."[4] These calls would come from Capital Health's executive on call and be directed to the equivalent person at Caritas.

[1] Exhibit 16.
[2] Exhibit 48.
[3] Exhibit 18; Testimony of David Megran, Transcripts, vol. 3, December 4, 2012, at 223-24.
[4] Testimony of Gordon Self, Transcripts, vol. 11, December 13, 2012, at 705.

Dr. Self said that these calls did not go beyond a heads-up. However, he was concerned that there might be consequences for Caritas if it did not "go to great lengths so that this person [identified by Capital Health] had some additional care," although he did not know of any instance where this concern led to "special things" being done for such patients.[5] He and others did not know what to do with the information, particularly because it came from Capital Health, which funded Caritas, and Capital Health had power over Caritas as a result. This uncertainty led to the development of the Caritas policy, which later became, in virtually identical form, the 2010 Covenant Health policy.

In contrast to the Caritas/Covenant Health policy, the Duckett policy appears to be based almost completely on speculation, exaggeration, or both, about the occurrence of preferential access. The draft AHS policy is based in part on the Duckett memo and so has the same evidentiary weakness as its foundation. However, unlike the Duckett memo, the draft AHS policy makes no claim about the supposed extent of preferential access.[6] The Covenant policy also makes no claims about the frequency of requests for special accommodation.

2. *Scope and purpose of the policies*

Both the AHS draft policy and the Duckett memo focus on preferential access or expedited care. The Covenant Health policy appears to cover a broader range of activities, speaking of "responding to special requests." It is clear from the testimony of Dr. Self that the perceived pressure to provide some form of "additional care" was the concern that led to the drafting of the policy. That "additional care" conceivably might be something other than preferential access or expedited care.

The Covenant Health policy also presents a much more extensive philosophical and ethical explanation of its positions than do the other two policies. The Covenant Health policy speaks of the Health Ethics Guide discussion of rationing resources and also delves into the ethical precept of *nonmaleficence* (do no harm). The document describes the

[5] Testimony of Gordon Self, Transcripts, vol. 11, December 13, 2012, at 737-38.
[6] Dr. Megran recollected that, after this inquiry was announced, Dr. Eagle, the current CEO of Alberta Health Services, "suggested that we were likely overdue in terms of taking the position paper I had written for Dr. Duckett and taking it to the step of having a formal policy." The paper Dr. Megran prepared was provided to the corporate policy section of AHS: Testimony of David Megran, Transcripts, vol. 3, December 4, 2012, at 224.

aim of the policy as being to clarify what is expected when Covenant Health is asked to accommodate special requests, and to provide an ethical framework to determine the moral legitimacy of each request. It also describes how the Health Ethics Guide affirms the equal value and dignity of all persons and the need to provide persons with the services they need, while ensuring that the common good is achieved.

The AHS draft policy states as its purpose "to establish direction for the management of requests for *improper preferential access* to publicly funded health services." This begs the question of why anyone would request something improper. The request presumably would be for preferential access of some type, with the hope that it would not be considered improper. It also begs the question of how one can manage requests for something improper other than by saying no. Since the draft policy requires that the CEO be notified of all requests for improper preferential access, is it contemplated that the CEO could decide that something improper would be allowed? Or, is the aim of the policy to send all requests for preferential access to the CEO so that he or she can decide whether it is proper or improper?

The Duckett policy document simply speaks of requests for preferential or expedited care generally. The inference is clear that all requests for preferential or expedited care are improper (since the document states that preferential or expedited care is not endorsed or encouraged by AHS and represents a practice that cannot be defended or supported). It is a much more direct statement of policy.

3. *Definitions*

The Covenant Health policy contains no definition of improper preferential access. It casts the issue more broadly in terms of "accommodating special requests." The Duckett and AHS policies set out definitions, but differ significantly in those definitions.

The Duckett policy defines preferential or expedited care as care that is rendered more quickly than medically indicated or more quickly than the current norm of the organization (meaning AHS), or care of a higher quality than the current norm. It therefore encompasses more than just the timeliness of access within its policy.

The Duckett policy does not use the term "improper preferential access" although, as noted, its description of preferential or expedited

care can only mean improper care. All requests for such care are to be addressed to the CEO of AHS. The policy does not appear to explain how to deal with requests for *proper* preferential or expedited care.

The Duckett policy appears to suffer the same flaw as the draft AHS policy. Both, in their wording, seem to envision sending requests for improper preferential access to senior officials. If the request is for improper access, it should be rejected out of hand. Both policies could benefit from clearer wording.

The draft AHS policy sets out a definition of improper preferential access as follows:

> Improper preferential access to publicly funded health services means using threat, influence or reward to get faster access to publicly funded health services or access to better publicly funded health services where the:
>
> - publicly funded health service is a finite resource; and
> - access is at the expense of other patients.

Clearly, this definition draws on the preamble to this inquiry's terms of reference by the use of the phrase "threat, influence or reward." And it suffers from the same limitation. As I discussed earlier, there are many ways of viewing improper preferential access. Not all of them constitute what I referred to as "corrupt" acts, such as the use of threats, influence or reward. There are also cases where preferential access is proper, or at least ethically or socially justifiable, even if not necessarily justifiable on medical grounds. For that reason, I chose to define improper preferential access in a more general manner as any policy, decision or action that cannot be medically or ethically justified, resulting in someone obtaining access in priority to others who are similarly situated.

The other difficulty with the AHS definition is that it limits itself by using qualifiers: *where* the publicly funded health service is a finite resource and *where* the access is at the expense of other patients. The first qualifier is almost meaningless since no publicly funded health service can be an infinite resource. The second raises the difficulty I spoke about as well in my discussion of a definition – the near

impossibility of proving that improper preferential access causes actual harm to others. As I explained there, even if there is no provable harm to a patient, there is harm to the system of publicly funded health care. The inability to demonstrate that someone's faster access or better care is at the expense of other patients should be no excuse for giving such preferential treatment, unless there is a medical or ethical justification.

The potential delays or other adverse effects on the care of patients should always be a factor when making health care decisions. It should not be a qualifier in the definition, as AHS has done. As I said before, if access is improper, harm can be assumed.

4. *Health care workers*

Both the Covenant Health policy and the draft AHS policy accept priority treatment for health care workers, generally where there is some public benefit. The Covenant Health policy speaks of the appropriateness of providing priority treatment where a person has the special skills and ability to serve the common good during a mass casualty event. It gives as an example an infectious disease specialist. Along lines similar to the Covenant Health policy, the draft AHS policy accepts that during a public emergency or disaster, timely access to health services may be appropriate and required for first responders and essential public workers. The Duckett memo is silent about preferential treatment for health care workers.

5. *Special treatment of board members and other VIPs*

The Duckett memo is directed at excluding preferential access for prominent individuals. In contrast, the Covenant Health policy seems to contemplate special treatment of some individuals "who may significantly contribute to the overall well-being and viability of the organization." It says that the principle of the common good "strives to find that balance where care for the good of the individual and care for the well-being of the organization are both considered." At least on the surface, this suggests that Covenant Health might consider accommodation based on the elevated status of the requester. At the same time, the policy speaks of the equal value and dignity of all persons. In its ethical analysis, it speaks of the Church considering the poor to be the ultimate special needs population deserving attention. Absent further explanation, the Covenant Health policy is confusing.

The draft AHS policy makes no mention of the special treatment of board members or other VIPs, although it does have a section on treatment of visiting dignitaries. It simply states that the provision of emergency care or service for a visiting dignitary (meaning a senior political or state official) is to be based on medical indications with "appropriate protocols" (whatever that means) to be followed.

6. *Who decides in preferential access cases*

The Covenant Health policy refers to the principle of subsidiarity, which acknowledges that decision-making should occur as close to the grass roots as possible. Only if there is disagreement about accommodating a special request should the request rise to a higher level, such as the executive on call. On the other hand, both the Duckett memo and the draft AHS policy move the initial decision-making responsibility higher up the organizational chain. The AHS policy says that the office of the AHS President and CEO must be notified of requests for preferential access. The Duckett memo similarly states that requests for preferential access or expedited care must be directed to the President and CEO.

7. *Discretion*

The Covenant Health policy does not constitute a blanket rejection of special requests. As noted above, the policy does not seek to dictate responses, but rather tries to provide an ethical/religious/moral framework to determine the legitimacy of requests. The goal is to allow those working closest to the issue to make decisions about accommodating special requests. This gives considerable discretion to different individuals, creating the potential for inconsistency in the application of the policy within the organization.

As noted, the procedures envisaged by the Duckett memo and AHS policy move decision-making responsibility higher up the organizational chain. This would promote greater consistency in the application of the policy than if different people lower down the chain made the decisions.

8. *Acceptable activities*

Both the Duckett policy and the AHS draft policy expressly approve of those in the health care system providing advice on how to navigate the system. The AHS policy goes on to say that such advice to any

individual who requests or requires such information is not only acceptable, but is endorsed and expected.

In my opinion, such advice is to be encouraged. No one has ever suggested that it would be improper.

Recommendation 12:

Develop a policy on preferential access

Alberta Health Services should complete its draft policy on preferential access, after taking into consideration this inquiry's findings and recommendations and after consultation with AHS staff, health care professionals and the public.

The policy should clearly describe which forms of preferential access are improper and should not be allowed, and how to respond to requests or attempts to obtain preferential access that is proper. The policy should be disseminated to the public and health care professionals to make the AHS position clear to all.

SECTION V: CONCLUSIONS AND RECOMMENDATIONS

I started this report by saying that the Canadian health care system is premised in part on the ideal of equitable access to necessary physician and hospital services – the principle that access should be determined by medical need. This principle is really a subset of a much larger conception of health care as a vehicle of distributive justice – the idea that health care should be distributed in an egalitarian manner so that no one is denied the care he or she needs simply because of non-medical criteria, such as an inability to pay.

Improper preferential access to publicly funded health services undermines those principles. However, as I discussed in this report, certain types of preferential access may be proper – that is, ethically or socially justifiable – despite the equitable access principle. One example may be front-line health workers receiving vaccinations ahead of the general public during an influenza outbreak so they remain healthy enough to vaccinate others. But society has yet to determine most of the situations where it will accept preferential access as being proper. The broadly based public discourse needed for such determinations has not yet occurred.

This inquiry has investigated incidents that revealed improper preferential access – the vaccination of professional hockey players during the H1N1 pandemic in 2009, some nurses vaccinating friends and family during that same period, and patients being fast-tracked for screening colonoscopies. These incidents are not representative of the health care system as a whole. However, they show certain parts of the system and the opportunities that may exist within it for improper preferential access.

The inquiry has also examined various practices that may open up avenues for improper preferential access – such as professional courtesy and what has been called the private patient path. These are practices that could benefit from a more considered analysis, and policies about them need clarification.

The recommendations in this report address the systemic issues arising from the incidents and practices examined by this inquiry. Some recommendations may be regarded as going beyond the strict

parameters of this inquiry's mandate. However, one cannot examine improper preferential access without looking at some of the systemic circumstances that lead to it – primarily lengthy wait times for consultations and procedures – and the possible measures available to address those circumstances.

This inquiry has clearly demonstrated that myriad opportunities exist for improper preferential access in the health care system because of the multiple ways to access that system and the wide discretion granted to physicians, other health care professionals and administrators. Lengthy wait times throughout the system also foster the motivation to jump the queue. That is human nature. And, as was repeatedly said during this inquiry, there would be no need to examine queue-jumping if there were no queues.

One must ask whether it is realistic to think that measures can be put in place to eliminate improper preferential access altogether. Are there simply too many holes to plug? And a further question must be asked – at what cost? Even if a system could be designed to guarantee that there would be no improper preferential access, there would certainly be an impact on how physicians, hospitals and clinics operate and organize their workloads. There is merit in maintaining the flexibility needed to meet the differing needs of patients. That is why most of the recommendations of this inquiry promote collaboration among various groups interested in health care to improve policies and guidelines, not mandatory rules and procedures.

The mere fact that this inquiry has been held may very well have caused people working in health care to consider the issue of improper preferential access more carefully and, if necessary, to modify their behaviour.

The literature review conducted for this inquiry found a lack of empirical evidence regarding the impact of improper preferential access on the health care system as a whole. The inquiry found no evidence that a patient had suffered adverse health consequences as a result of any of the incidents and practices of improper preferential access examined. What improper preferential access exists in the system – apart from areas such as workers' compensation cases, where legislation creates a system of preferential access – involves an extremely small percentage of the total cases in the public health care system. If very few persons benefit from improper preferential access,

and there is no evidence of others being harmed by it, there may be no significant threat in practice to the egalitarian aims of our health care system.

However, the perception remains that some receive faster access to health care because of status or connections, not medical need. This is just as damaging to confidence in the public health care system as the actual cases of queue-jumping identified in this report. Those who deliver health care must be prepared to challenge the perception as well as address the reality.

The expert witnesses who testified at this inquiry cited education as a means to reduce improper preferential access and increase public knowledge about the workings of the health care system. Education can help medical professionals understand the potential harm that can be caused by improper preferential access and the systemic harm that results from public perceptions of the extent and unfairness of improper preferential access. It can help distinguish between ethical physician advocacy and advocacy that crosses the line into pressure for some improper preference. Educating the public can help alleviate misunderstandings about how the health care system functions and also spur greater public involvement in discussions about all aspects of the health care system. The sustainability of Alberta's public health care system depends in large measure on involving the public in addressing the challenges facing the system and developing solutions for those challenges.

Improper preferential access is a minor component of the public health care system. However, because of the public perception about the extent of improper access, this issue corrodes public trust in the system. I hope that, with this report and these recommendations, the work of this inquiry will lead to measures that will reinforce that trust.

RECOMMENDATIONS

Recommendation 1

Strengthen the queue-jumping provisions of the *Health Care Protection Act*

The Government of Alberta should amend section 3 of the *Health Care Protection Act* to:

- broaden the scope of the prohibited forms of inducement;
- have it apply to all types of insured health services; and
- include a mandatory reporting requirement with provisions for the protection of people who make a report in good faith. (Section II, Chapter 2, Part C)

Recommendation 2

Expand whistleblower protection

The Government of Alberta should amend the *Public Interest Disclosure (Whistleblower Protection)* Act to include health care professionals, such as physicians, who are not employees but who are contracted by Alberta Health Services and/or the government to provide health care services. (Section II, Chapter 2, Part F)

Recommendation 3

Clarify the scope and application of professional courtesy

The College of Physicians & Surgeons of Alberta, working with the Alberta Medical Association, the College & Association of Registered Nurses of Alberta and other representative bodies, as well as public representatives, should closely examine the practice and ethical implications of professional courtesy with a view to defining its scope and application and providing guidelines to health care professionals. (Section II, Chapter 2, Part G)

Recommendation 4

Reduce wait times

Alberta Health Services should continue its current efforts to improve access to health care overall and to reduce associated wait times. It should also consider implementing a comprehensive wait time measurement system. (Section II, Chapter 3, Part B)

Recommendation 5

Develop and implement wait list management strategies

Alberta Health Services, in consultation with appropriate sectors of the health care system and the public, should develop and implement consistent and comprehensive wait list management strategies which include:

- standardized concepts and terms;
- standardized prioritization criteria, both within a given specialty and among different specialities, to better organize the allocation of shared resources (such as operating room time);
- centralized referral and booking systems;
- a system of audit and evaluation; and
- publicly accessible information on wait times, referrals and bookings, and service availability by provider (physician, clinic or hospital). (Section II, Chapter 3, Part C)

Recommendation 6

Develop standardized referral procedures and booking systems

Alberta Health Services should continue to develop standardized referral procedures and centralized triage and booking systems to improve access and reduce referral wait times. Any such systems should be audited and evaluated, and education programs should be

given to service providers about how to use new systems. (Section II, Chapter 3, Part D)

Recommendation 7

Consider creating the position of Health Advocate

The Government of Alberta, in consultation with Alberta Health Services and the College of Physicians & Surgeons of Alberta, should consider establishing an independent office of Health Advocate. The role of the Health Advocate would be to provide advice and advocacy assistance to patients and to help resolve patient complaints. (Section II, Chapter 4, Part C)

Recommendation 8

Develop a policy on courtesy calls

Alberta Health Services, in consultation with other sectors of the public health care system, should develop a policy on information or courtesy calls that clearly defines the circumstances under which such calls should be made, to whom they can be made, and how those receiving such calls should respond to them. (Section III, Chapter 2)

Recommendation 9

Develop a policy on special accommodation during a pandemic

As part of any pandemic preparedness plan, Alberta Health Services should develop a policy on how to address requests for special accommodation. (Section III, Chapter 4)

Recommendation 10

Develop policies for the private patient path

Alberta Health Services, in consultation with appropriate stakeholders, should analyze the ethical and practical implications of the private

patient path and develop appropriate policies for emergency department personnel and physicians. (Section III, Chapter 6)

Recommendation 11

Strengthen access, triage and booking procedures

Alberta Health Services should put measures in place to ensure that:

- access, triage and booking procedures at each Alberta Health Services facility are clearly designated as procedures that must be followed by all medical professionals and staff members;
- staff members are trained about access, triage and booking procedures;
- senior management at each facility is trained on procedures to receive and handle staff concerns regarding non-compliance with procedures by anyone; and
- staff members are aware of the protections available under applicable whistleblower legislation and the procedures for using the legislation. (Section III, Chapter 8)

Recommendation 12

Develop a policy on preferential access

Alberta Health Services should complete its draft policy on preferential access, after taking into consideration this inquiry's findings and recommendations and after consultation with Alberta Health Services staff, health care professionals and the public.

The policy should clearly describe which forms of preferential access are improper and should not be allowed, and how to respond to requests or attempts to obtain preferential access that is proper. The policy should be disseminated to the public and health care professionals to make the AHS position clear to all. (Section IV)

APPENDIX 1: ADMINISTRATIVE LESSONS LEARNED FOR FUTURE INQUIRIES

I want to comment on certain aspects of the establishment and organization of the inquiry. My aim is to explain some of the logistical and organizational difficulties this inquiry encountered and to suggest how to avoid such difficulties in future inquiries. This is the first inquiry held pursuant to section 17 of the *Health Quality Council of Alberta Act*. I hope that my comments will be useful to the government when it establishes future inquiries under this or other legislation.

A. Establishment of the inquiry

I noted in the body of the report that, unlike most inquiries, this inquiry was not established to investigate a specific event. The allegations that prompted the inquiry were widely reported in the media, but no investigation into those allegations preceded the inquiry. If the government's aim was to examine just those allegations, there were alternatives available to it, including departmental investigations, internal inquiries within Alberta Health Services (AHS) or a ministerial task force. Also, if the government wanted to limit the inquiry's mandate to examining just those allegations, it could have said so in the inquiry's terms of reference. But the terms of reference were worded in much more general terms as I discussed earlier.

I say this because a public inquiry is a significant undertaking. It is time-consuming and costly. The decision to establish a public inquiry should be taken with these factors in mind. And it makes no difference whether it is a public inquiry under the *Health Quality Council of Alberta Act* or the *Public Inquiries Act*. Both acts stipulate that it must be in the public interest for an inquiry to be called. A noted Canadian expert, Prof. Ed Ratushny, describes commissions of inquiry as "residual institutions" because they are invoked as the remaining alternative when other institutions or processes are inadequate.[1]

The traditional Canadian view is that a public inquiry is an exceptional measure and that only matters of very significant public importance should be entrusted to such a body.[2] This is because a public inquiry –

[1] Ed Ratushny, *The Conduct of Public Inquires: Law, Policy and Practice* (Toronto: Irwin Law, 2009) at 20.
[2] Simon Ruel, *The Law of Public Inquiries in Canada* (Toronto: Carswell, 2010) at 6.

even with its positive attributes of independence and transparency – is highly coercive. It can compel the attendance of witnesses and the production of documents. For this reason, the focus of the inquiry should be something of sufficient public concern to warrant use of these coercive powers.

I have already commented in the report on the difficulties caused by the lack of any prior investigation into the allegations made by Drs. Stephen Duckett and Raj Sherman. The long list of recent commissions of inquiry in Canada shows that in practically every case the inquiry was triggered by some event that raised a matter of vital public concern. Usually the event had already been investigated by some government agency. Take, for example, the 2008 Commission of Inquiry into Certain Allegations Respecting Business and Financial Dealings between Karlheinz Schreiber and the Right Honourable Brian Mulroney. That inquiry, too, had as its origin certain allegations. But before the decision was made to order the inquiry, a solid body of evidence existed, including depositions from a civil suit, reports from police investigations and parliamentary committee hearings and an independent review of the allegations.

My point is simply that a great deal of thought needs to be put into the decision to proceed with a public inquiry. Any decision should be informed by some preliminary investigation. A cursory investigation of the Duckett and Sherman allegations would have quickly revealed them to be groundless.

B. Consultation

The order in council establishing this inquiry was issued on February 28, 2012. I was appointed as the "panel" to conduct the inquiry on March 16, 2012. There was no opportunity for me to discuss the inquiry's terms of reference before the order in council was issued.

It is now accepted practice for the intended commissioner of an inquiry to review the terms of reference with government prior to the terms being formalized in the order in council.[3] In its protocol concerning the appointment of federally appointed judges to head commissions of inquiry, the Canadian Judicial Council urges a review of the terms of reference before the judge is appointed and the terms are set. As the

[3] Ed Ratushny, *The Conduct of Public Inquires: Law, Policy and Practice* (Toronto: Irwin Law, 2009) at 150-154.

protocol states, "Even in the face of perceived urgency, taking the time to structure the inquiry properly is important for the government, the judiciary and the public interest."[4]

Prior consultation is important primarily because the commissioner's principal task is to ensure that it is possible to carry out the work described in the terms of reference. Consultation provides an opportunity to correct any ambiguity in the terms of reference; ensure that any time limit on the inquiry's work is realistic and sufficient for the inquiry to carry out its work; and outline administrative and funding arrangements satisfactory to both government and commissioner.

This inquiry faced a major delay because administrative and financial arrangements had not been elaborated and agreed upon until well after my appointment. This delay was compounded by the provincial election. Some of the initial proposals for the financial arrangements for the inquiry involved procedures I thought could be problematic for the inquiry's independence. I do not think these procedures were intended to do that. They merely reflected the insufficient planning that preceded the order in council. That also meant that it took several months for the inquiry to receive funds to finance its operations. This delayed its work and eventually was one of the causes that necessitated a request to extend the reporting deadline.

I received a great deal of assistance from the Health Quality Council of Alberta and its CEO, Dr. John Cowell, in the early weeks after my appointment, as did my executive director once she was retained in mid-April 2012. But the inquiry's funding was not advanced until September. Because of this, the inquiry could not get fully up to speed for several months after it was officially established. In the future, advance planning and consultation could help avoid these delays.

C. The tripartite arrangement

The main administrative condition imposed by the government was that the Health Quality Council of Alberta administer the inquiry's funding. This resulted in what I call a tripartite arrangement between the inquiry, the Council and the government.

[4] Canadian Judicial Council, *Protocol on the Appointment of Judges to Commissions of Inquiry* (August 2010) at 5.

The inquiry's terms of reference, as I noted elsewhere, required me to prepare a budget and submit it to the government for approval. That was done on June 11, 2012. Cabinet approved it on July 25, 2012. A lengthy process followed, leading to two agreements. The first, executed in late August, was between the province and the Council. It provided for advancing the amount of the inquiry's budget to the Council and the disbursement of those funds to the inquiry after it submitted invoices. The second agreement, between the Council and me as "the panel," was not completed until September 17, 2012. Only then were funds released to the Council and made available for the inquiry's work.

These agreements led to a considerable duplication of effort in monitoring the inquiry's finances. The agreement between the Council and "the panel" required the inquiry to establish an internal system of financial controls. The inquiry was also required to submit quarterly financial reports to the Council. The agreement between the Council and the province required the Council to also establish an internal control system for the disbursement of funds. The Council was also required to provide quarterly financial reports to the province in addition to transmitting to the province the reports provided by the inquiry. As I said, this resulted in a duplication of effort. It also unnecessarily increased the call on the inquiry budget, since the inquiry had to pay for the administrative services provided by the Council.

These arrangements were imposed on the inquiry without meaningful prior consultation. The government is ultimately responsible for the expenditure of public funds and can and should demand strict financial accountability. But arrangements such as these simply increased the burden on the inquiry executive director and her staff without any increase in already strong measures of financial accountability.[5]

I understand that the Privy Council Office has developed policies and procedures to guide federally appointed commissions of inquiry on organizational matters including contracts, procurement of goods and services and employment of staff, and to assist on interactions with the federal government.[6] It would be extremely helpful if the Alberta

[5] The inquiry's books and records were also available for audit and examination at any time by the Auditor General of Alberta.
[6] Commission of Inquiry into the Decline of Sockeye Salmon in the Fraser River, *The Uncertain Future of Fraser River Sockeye, Final Report*, vol. 3 (Ottawa: Public Works and Government Services Canada, 2012) at 116.

government were to establish general procedures and guidelines for public inquiries. That way, each new inquiry would not need to start from scratch.

D. Senior contact person for public inquiries

It would also be helpful to have a senior official in the cabinet office designated as the contact person for any provincial inquiry. That official might even be as senior as the Secretary to Cabinet. Someone must have sufficient authority to make prompt decisions on inquiries' administrative and financial matters and to respond to emerging issues before they become a needless distraction for the inquiry. When an inquiry faces a deadline, issues (such as the finalization of financing agreements) must be addressed quickly. By that, I mean less time than the almost two months to finalize the agreements for this inquiry. Furthermore, since cabinet must approve any change to the inquiry's terms of reference and implement the change through an order in council, it only makes sense to have a senior cabinet official who is fully familiar with the inquiry's operations available to facilitate this. This is imperative if an inquiry, whether under the *Health Quality Council of Alberta Act* or under the *Public Inquiries Act,* sets up an independent administrative structure to support its work.

This inquiry did not have the benefit of such a senior official. The main contact was a senior counsel in the office of the Minister of Health. While this individual was very helpful, it was not the same as having someone at a cabinet secretary or deputy minister level.

E. A suggestion for the future

One of the more troublesome issues in the early days after my appointment was the extent of the role to be played by the Health Quality Council in support of this inquiry. The terms of reference enabled me "from time to time" to request administrative and other support from the Council or government. However, the information communicated to me at the time of my appointment was that the inquiry should be completely independent and therefore the role of the Council was to be minimized.

The government had contemplated the question of the role of the Council in inquiries when it introduced Bill 24, which became the *Health Quality Council of Alberta Act*. During the legislative debates on the Bill in November 2011, questions were raised about the extent of

Council involvement in an inquiry called under section 17 of the Act. The Minister of Health said as follows:

> Once a panel is appointed by the council, the panel will be authorized to hire its own staff resources, including lawyers to advise it. *I also want to reiterate that once the panel is appointed, the council has no further role in the inquiry*.[7] [Emphasis added]

However, the present inquiry saw the Council take a very active role in the inquiry's operations because of the funding agreements I described earlier. The Council certainly never attempted to interfere with how the inquiry pursued its mandate. But it played a significant oversight role in the financial arrangements for the inquiry. The government directed it to assume this role. It cannot be said that the Council played no further role in the inquiry after it appointed the Panel, as the Minister in 2011 promised of the relations between the Council and public inquiries under the Act.

The tripartite arrangement, as I call it, has caused me to consider whether it is strictly necessary to keep the Council separate from the work of an inquiry such as this one. Traditionally public inquiries, such as ones appointed under the *Public Inquiries Act*, are designed to be independent in all respects, including their administration. But there is no reason to equate an inquiry under section 17 of the *Health Quality Council of Alberta Act* with an inquiry under the *Public Inquiries Act* in all aspects. They share the same powers but they do not have to mirror each other in all administrative aspects.

An inquiry under section 17 must be related to a health matter. The Council has expertise in investigating health matters. The Council itself enjoys a great degree of independence. It is not an agent of the Crown and its board (appointed by the Lieutenant Governor in Council) has control over its business and management.

Therefore, I suggest that an inquiry under section 17 – even though headed by an individual or group, possibly a judge or judges, acting as "the Panel," independent of the Council – have the option of using the administrative apparatus of the Council. The inquiry would still be

[7] Legislative Assembly, *Alberta Hansard*, No. 43e (November 29, 2011) at 1480 (Fred Horne).

independent provided that the Panel is seen as independent and behaves accordingly. The advantage would be that the Panel could draw extensively on the resources of the Council, particularly its experience in conducting investigations and quality assurance reviews. There would be no need to establish a completely separate administrative structure for such an inquiry and no need then for complicated and duplicative financial arrangements. This should at least be an option for the Panel. There need not be an assumption that a section 17 inquiry must be administratively separate from the Council.

If a matter is of such vital public concern that a completely independent inquiry is warranted, the inquiry should be appointed under the *Public Inquiries Act*. Then, as is traditional for commissions of inquiry, the inquiry can set up a separate administrative and financial structure. Most important, the inquiry can establish a direct relationship with a senior cabinet official, as I suggested previously, without a government department or, as with this inquiry, the Council playing an intermediary role.

I offer this as a suggestion for future inquiries with a view to avoiding some of the difficulties this inquiry encountered.

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Taryn Burnette	Dr. Jonathan Love, Dr. Valerie Boswell

LIST OF WITNESSES

Prof. William Lahey, *Associate Professor of Law at Dalhousie University in Halifax* **Dr. James Saunders**, *Health Consultant* **Dr. David Megran**, *Executive Vice-President and Chief Medical Officer, Alberta Health Services* **Dr. Stephen Duckett**, *former President and Chief Executive Officer, Alberta Health Services* **Ms. Sheri Drozda**, *Charge Nurse, Foothills Medical Centre* **Dr. Paul Parks**, *Chief Emergency Physician, Medicine Hat* **Dr. Brian Holroyd**, *Chair, Department of Emergency Medicine, University of Alberta* **Dr. David Diamond**, *Senior Vice-President, Human Resources, Alberta Health Services* **Ms. Deborah Gordon**, *Senior Vice-President, Chief of* **Minister Fred Horne**, *Minister of Health* **Dr. Max Findlay**, *Surgeon, Edmonton*	*Nursing, Alberta Health Services* **Ms. Kathy Taylor**, *Emergency Manager, Lougheed Hospital* **Mr. Donald Christensen**, *Area Manager, Urgent Care, Sheldon Chumir Health Centre* **Mr. Ron Liepert**, *former Minister of Health* **Ms. Patty Grier**, *AHS Chief of Staff, Corp. Secretary* **Ms. Lynn Redford**, *former Calgary Health Region Employee* **Mr. Brian Hlus,** *Director of Government Affairs, Capital Health 1999-2008* **Dr. Gordon Self**, *Vice President, Missions, Ethics and Spirituality, Covenant Health* **Ms. Brigitte McDonough**, *Director of Critical Care, University of Alberta Hospital, Alberta Health Services* **Dr. Raj Sherman**, *MLA for Edmonton-Meadowlark* **Mr. Brian Mason**, *MLA for Edmonton-Highlands-Norwood* **Mr. Harry Chase**, *Former Liberal MLA*	**Mr. Nikola Juric**, *Retired, Former Nurse, University of Alberta Hospital* **Ms. Sheila Weatherill**, *President and Chief Executive Officer, Capital Health 1996-2008* **Mr. Shawn Hillhouse**, *Patient Care Manager, Stollery Childrens' Hospital* **Ms. Skyla Lungren**, *Manager of Operating/Bookings, Foothills Hospital* **Ms. Janice Stewart**, *Executive Director of Surgery, Rockyview Hospital* **Ms. Jill Woodard**, *Executive Director, Emergency & Surgery Services, Alberta Childrens' Hospital* **Dr. Nicholas Mohtadi**, *Orthopaedic Surgeon, Sports Injury Epidemiology, Clinical Trials, University of Calgary* **Dr. William Anderson**, *Alberta Health Services: JLW* **Mr. Neil Wilkinson**, *former Board Chair, Capital Health Services* **Dr. Trevor Theman**, *Registrar, College of Physicians & Surgeons of Alberta*

Appearances

Dr. James Thorne, *Primary Care Physician/Sports Medicine, Calgary Flames* **Minister Ken Hughes**, *former AHS Board Chair* **Mr. Jack Davis**, *former Chief Executive Officer, Calgary Health Region* **Ms. Michelle Bosch**, *Public Health Nurse, Rockyview Hospital* **Ms. Debbie Hyman**, *former Clinic Manager, Brentwood Clinic* **Ms. Lori Anderson**, *Vice-President, South Health Campus* **Mr. David Beninger**, *Clerk 3 Casual, Colon Cancer Screening Centre* **Ms. Dayna Sutherland**, *Off-Site Data Entry Clerk, Colon Cancer Screening Centre* **Ms. Samantha Mallyon**, *Clerk 3, Colon Cancer Screening Centre* **Ms. Kelly Hawken**, *Executive Assistant to the Executive Director of Rural Hospitals, Alberta Health Services* **Dr. Ronald Bridges**, *Founder, Helios Wellnes Centre*	**Deputy Premier Thomas Lukaszuk**, *MLA for Edmonton-Castle Downs, Minister of Enterprise and Advanced Education* **Dr. Alaa Rostom**, *Gastroenterologist, Colon Cancer Screening Clinic* **Dr. Francois Belanger**, *Senior Vice President, Medical Director - Calgary Zone, Alberta Health Services* **Ms. Linda Duffley**, *Director of Public Health Programs, Edmonton Zone, Alberta Health Services* **Ms. Susan Smith**, *Clinical Development Nurse, Communicable Disease Control, Bonnie Doon Public Health Centre, Edmonton Zone, Alberta Health Services* **Ms. Arlene Lohan**, *Manager, Province-wide Immunization Program, Standards and Quality, Alberta Health Services* **Ms. Judy Brosseau**, *Operations Manager, North Gate Clinic, Edmonton, Alberta Health Services* **Ms. Christine Westerlund**, *Director of Critical Care and Operative Services, Stollery Childrens' Hospital, Alberta*	**Ms. Barb Kathol**, *Executive Director, Foothills Hospital* **Dr. Jonathan Love**, *Gastroenterology Site Chief - Foothills Medical Centre, Regional Chair of Endoscopy and Head of the Therapeutic Endoscopy Group* **Dr. Valerie Boswell**, *General Practitioner and Contractor with Forzani & Macphail Colon Cancer Screening Centre* **Mr. Kyle Cridland**, *Triage Nurse, Foothills Medical Centre* **Ms. Leah Tschritter-Pawluk**, *Clinic Operator, Helios Wellness Centre* **Dr. Douglas Caine**, *Physician, Helios Wellness Centre* **Dr. Chen Fong**, *Founder, Helios Wellness Centre* **Ms. Darlene Pontifex**, *Clinic Manager, Colon Cancer Screening Centre*

Ms. Olga Koch, *Administrative Assistant, Colon Cancer Screening Centre* **Dr. Mark Swain,** *Professor of Medicine – University of Calgary, Section Chief (Gastroenterology) – Calgary Zone, Alberta Health Services* **Dr. Lynette Reid**, Panelist – *Associate Professor, Department of Bioethics, Faculty of Medicine, Dalhousie University* **Ms. Pam Whitnack**, Panelist – *President – Whitnack and Associates Ltd., Former Executive Vice President – Rural, Public and Community Health, Alberta Health Services*	*Health* **Dr. Brian Goldman**, Panelist – *Assistant Professor, Department of Family and Community Medicine, University of Toronto* **Dr. David Alter**, Panelist – *Associate Professor, Department of Medicine, University of Toronto* **Dr. John Church,** Panelist – *Associate Professor, Department of Political Science and Centre for Health Promotion Studies, University of Alberta* **Dr. Owen Heisler,** Panelist – *Assistant Registrar – College of Physicians and Surgeons of Alberta and Assistant Clinical Professor, University of Alberta*	

APPENDIX 4: RELEVANT DOCUMENTS

(a) ORDERS IN COUNCIL

i. February 28, 2012

O.C. 80/2012

February 28, 2012

The Lieutenant Governor in Council makes the Order in the attached Appendix.

For Information only

Recommended by:	Minister of Health and Wellness
Authority:	Health Quality Council of Alberta Act (section 17)

APPENDIX

ORDER

PUBLIC INQUIRY INTO HEALTH SYSTEM MATTERS

WHEREAS:

- Allegations have been made that some individuals are, or have been, given improper preferential access to publicly funded health services;

- Access to publicly funded health services is properly based on patient need and the relative acuity of a patient's condition;

- It is improper to gain access to publicly funded health services through threat, influence or favour

- It is in the public interest to assure Albertans that the publicly funded health care system provides for fair and appropriate access to health services; and

- The Lieutenant Governor in Council considers it to be in the public interest that a public inquiry be held to make recommendations to prevent the possibility of any person being given improper preferred access to publicly funded health services.

THEREFORE:

Pursuant to section 17 of the *Health Quality Council of Alberta Act*, the Lieutenant Governor in Council orders that a public inquiry be held concerning the possibility of improper preferential access being given to publicly funded health services and, specifically, the terms of reference for the inquiry shall be to consider:

1) Whether improper preferential access to publicly funded health services is occurring; and

2) If there is evidence of improper preferential access to publicly funded health services occurring, make recommendations to prevent improper access in the future.

Further, the board of the Health Quality Council of Alberta is directed to appoint a Panel of one or more qualified persons to have conduct of the inquiry, including a chair of the Panel if the Panel includes more than one person, and:

3) In accordance with section 17 of the *Health Quality Council of Alberta Act*, the Panel shall have all the powers, privileges and immunities of a commissioner under the *Public Inquiries Act.*

4) The Panel shall conduct the inquiry, prepare a report setting out the findings and recommendations of the Panel and submit the report to the Speaker of the Legislative Assembly no later than April 30, 2013

5) The Panel may retain such experts and advisors as are reasonably required to assist it in achieving the objective of the inquiry.

6) The Panel is directed to prepare a budget and submit it to the Lieutenant Governor in Council, through the Minister of Health and Wellness, for review and approval. The Panel shall put a system of budget monitoring and reporting in place. Budget and expenditure reporting shall be to the Minister of Health and Wellness, and the Minister shall make provision for funding the inquiry, including the compensation of Panel members, in accordance with the approved budget.

7) The Panel is directed to develop and submit a policy to the Lieutenant Governor in Council, through the Minister of Health and Wellness, on whether or not assistance will be provided to witnesses or interveners to prepare submissions or for the costs of legal counsel. Costs for legal counsel must only be provided in accordance with the Government of Alberta's established rates for retaining external legal counsel.

8) The Panel is directed to provide prior notice to the Lieutenant Governor in Council, through the Minister of Health and Wellness, at any point where it considers it advisable to make budget adjustments that are reasonably required to assist it in achieving the objective of the inquiry.

9) The Panel may from time to time request administrative and other support from the Health Quality Council of Alberta or from the Government of Alberta, through the Minister of Health and Wellness, if it considers it appropriate and necessary for the proper conduct of the inquiry.

10) The Panel may request the Lieutenant Governor in Council, through the Minister of Health and Wellness, to clarify any provision of this Terms of Reference or to modify any provision of this Terms of Reference if the

Panel is of the opinion clarification or modification is necessary for the proper conduct of the inquiry.

ii. July 25, 2012

O.C. 264/2012

July 25, 2012

The Lieutenant Governor in Council

1) approves the Panel's budget, with the modifications and conditions set out in Appendix 1, for the Health Services Preferential Access Inquiry;

2) accepts the Panel's Funding Policy for Witnesses and Interveners set out in Appendix 2.

For Information only

Recommended by: Minister of Health

Authority: O.C. 80/2012

Appendix #1 – Modifications and Conditions to Inquiry Budget 2012-2013

1) The Panel's proposed $10,000,000.00 budget, less the 20% contingency allotted in the inquiry budget for cost overruns, is approved. The Panel may submit a request to the Lieutenant Governor in Council, through the Minister of Health, for the additional $1,742,000.00, at a later date, if necessary.

2) The executive director for the inquiry, in conjunction with the Health Quality Council of Alberta, must establish and implement a system of internal budget monitoring and spending oversight to conduct the inquiry and prepare reports as required by the terms of the grant agreement between Her Majesty the Queen in Right of Alberta as represented by the Minister of Health and the Health Quality Council of Alberta.

3) The Panel may submit a second budget to the Lieutenant Governor in Council, through the Minister of Health, for funding for interveners and witnesses, at a later date, if necessary.

Appendix #2 - Funding Policy for Witnesses and Interveners

Witnesses and interveners may apply for financial assistance

7-2.1 Upon application by any witness or intervener who the Commissioner has recognized as having standing at the Inquiry, or for any part of the Inquiry, the Commissioner may make a decision that the applicant should receive financial assistance for the purpose of preparing submissions, or for the costs of legal counsel, to facilitate participation in the Inquiry (a "Funding Decision").

Funding Decisions may be made in any amount and subject to terms and conditions

7-2 The Commissioner may make a Funding Decision in any amount, whether or not the Funding, as recommended, would fully indemnify the applicant for all costs of participating at the Inquiry.

7-3 The Commissioner may make a Funding Decision subject to any terms and conditions, including that financial assistance should be available to an applicant only as part of a group comprised of two or more persons, groups of persons or entities whose interests and perspectives overlap. How to apply for financial assistance

7-4 An application for financial assistance may be made by a proposed witness or intervener concurrently with an application for standing.

7-5 An application for financial assistance must be made in writing, and will be decided by the Commissioner based solely on the written record, without an oral hearing, unless an oral hearing is directed by the Commissioner.

7-6 An application for financial assistance must be supported by:

(a) a sworn statutory declaration proving that the applicant does not have sufficient financial resources from any source to enable it to meaningfully participate in the Inquiry;

(b) a written budget outlining the applicant's proposed involvement in the Inquiry and the estimated costs to be incurred by the applicant; and

(c) a written proposal as to how the applicant will account for funds received.

What the Commissioner will consider

7-7 In addition to the submissions of an applicant, the Commissioner will also consider other factors when deciding the application for financial assistance, including:

(a) whether the applicant is a witness, an intervener or both;

(b) in the case of applicants who are witnesses, whether the applicant's testimony is being compelled by Commission Counsel;

(c) the nature and extent of the applicant's interest, including whether the applicant might be adversely affected by the report of the Commissioner;

(d) whether the applicant has a demonstrated record of concern for and commitment to the interest it seeks to represent;

(e) whether the applicant has special experience or expertise relevant to the Inquiry's mandate; and

(f) whether the applicant could reasonably be included in a group with others of similar or overlapping interests.

Financial assistance is not available for the following

7-8 Notwithstanding Rule 7-7, the Commissioner will not endorse financial assistance:

(a) for costs of legal counsel other than in accordance with the Government of Alberta's established rates for retaining external legal counsel (attached);

(b) for costs incurred by the applicant before the application for a funding recommendation was made and considered; and

(c) for disbursements other than in accordance with the Court of Queen's Bench Costs Manual.

7-9 The Commissioner will make a request to the Lieutenant Governor in Council for the allocation of funds in respect of any Funding D

iii. November 21, 2012

O.C. 383/2012

November 21, 2012

The Lieutenant Governor in Council

1) approves the budget for funding for interveners and witnesses for the Health Services Preferential Access Inquiry as set out in Appendix 1;

2) 2 accepts the process for allocation of funds for interveners and witnesses approved by the Inquiry Panel at the hearings as set out in Appendix 2.

For Information only

Recommended by: Minister of Health

Authority: Orders in Council 80/2012 and 264/2012

Appendix #1 – Budget for Funding for Interveners and Witnesses

1) The Panel's proposed budget for $125,000, as set out in the Panel's Rulings on Standing and Funding, dated October 19, 2012, is approved.

2) In anticipation of further applications for funding for interveners and witnesses, acknowledged in the Panel's Rulings on Standing and Funding dated October 19, 2012 as well as the Panel's letter to the Minister of Health dated October 22, 2012, an additional $200,000, to be used for any future financial assistance rulings for interveners and witnesses, is approved.

3) The executive director for the inquiry, in conjunction with the Health Quality Council of Alberta, will utilize a system of internal budget monitoring and spending oversight to ensure the disbursement and reporting on the

financial assistance is in compliance with the terms of the grant agreement between Her Majesty the Queen in Right of Alberta as represented by the Minister of Health and the Health Quality Council of Alberta and is consistent with the financial assistance policy

4) If the Panel exceeds the total amount approved under sections 1 and 2, the Panel may submit a third budget to the Lieutenant Governor in Council, through the Minister of Health, for additional funding for interveners and witnesses, at a later date, if necessary.

Appendix #2 - Process for Allocation of Funds for Interveners and Witnesses

5) The sum of $325,000 will be advanced to the Health Quality Council of Alberta in accordance with the terms of the grant agreement between Her Majesty the Queen in Right of Alberta as represented by Minister of Health and the Health Quality Council of Alberta and will be held in a separate account pending further documentation from the Panel.

6) The Panel will submit any rulings authorizing financial assistance for an intervener or witness to the Health Quality Council of Alberta with a copy to the Minister.

7) The Panel will submit the necessary invoices and documentation to the Health Quality Council of Alberta when requesting payment of the authorized financial assistance for interveners and witnesses. The Health Quality Council of Alberta shall disburse the funds as requested from the monies available, subject to compliance with the grant agreement and the financial assistance policy.

iv. March 6, 2013

O.C. 40/2013

March 6, 2013

The Lieutenant Governor in Council amends Order in Council numbered O.C. 80/2012 by striking out paragraph 4 of the Appendix and substituting the following:

4) The Panel shall

(a) conduct and complete the inquiry by April 30, 2013,

(b) complete its review of the evidence and prepare a report setting out its findings and recommendations by August 31, 2013, and

(c) submit the report to the Speaker of the Legislative Assembly on or before August 31, 2013.

For Information only

Recommended by: Minister of Health

Authority: Health Quality Council of Alberta Act (section 17)

(b) FUNDING POLICY

Witnesses and interveners may apply for financial assistance

1-1 Upon application by any witness or intervener who the Commissioner has recognized as having standing at the Inquiry, or for any part of the Inquiry, the Commissioner may make a decision that the applicant should receive financial assistance for the purpose of preparing submissions, or for the costs of legal counsel, to facilitate participation in the Inquiry (a "Funding Decision").

Funding Decisions may be made in any amount and subject to terms and conditions

1-2 The Commissioner may make a Funding Decision in any amount, whether or not the Funding, as recommended, would fully indemnify the applicant for all costs of participating at the Inquiry.

1-3 The Commissioner may make a Funding Decision subject to any terms and conditions, including that financial assistance should be available to an applicant only as part of a group comprised of two or more persons, groups of persons or entities whose interests and perspectives overlap.

How to apply for financial assistance

1-4 An application for financial assistance may be made by a proposed witness or intervener concurrently with an application for standing.

1-5 An application for financial assistance must be made in writing, and will be decided by the Commissioner based solely on the written record, without an oral hearing, unless an oral hearing is directed by the Commissioner.

1-6 An application for financial assistance must be supported by:

a) a sworn statutory declaration proving that the applicant does not have sufficient financial resources from any source to enable it to meaningfully participate in the Inquiry;

b) a written budget outlining the applicant's proposed involvement in the Inquiry and the estimated costs to be incurred by the applicant; and

c) a written proposal as to how the applicant will account for funds received.

What the Commissioner will consider

1-7 In addition to the submissions of an applicant, the Commissioner will also consider other factors when deciding the application for financial assistance, including:

a) whether the applicant is a witness, an intervener or both;

b) in the case of applicants who are witnesses, whether the applicant's testimony is being compelled by Commission Counsel;

c) the nature and extent of the applicant's interest, including whether the applicant might be adversely affected by the report of the Commissioner;

d) whether the applicant has a demonstrated record of concern for and commitment to the interest it seeks to represent;

e) whether the applicant has special experience or expertise relevant to the Inquiry's mandate; and

f) whether the applicant could reasonably be included in a group with others of similar or overlapping interests.

Financial assistance is not available for the following

1-8 Notwithstanding Rule 1-7, the Commissioner will not endorse financial assistance:

a) for costs of legal counsel other than in accordance with the Government of Alberta's established rates for retaining external legal counsel (attached);

b) for costs incurred by the applicant before the application for a funding recommendation was made and considered; and

c) for disbursements other than in accordance with the Court of Queen's Bench Costs Manual.

1-9 The Commissioner will make a request to the Lieutenant Governor in Council for the allocation of funds in respect of any Funding Decisions.

(c) RULES OF PRACTICE & PROCEDURE

I. General

1. These Rules of Practice and Procedure govern the public inquiry established by Order in Council, O.C. 80/2012 of February 28, 2012.

2. These Rules may be dispensed with or amended from time to time, in the discretion of the Commissioner, to ensure fairness and efficiency. The Commissioner may make any direction necessary to deal with any issue arising during the course of the Inquiry which is not addressed in these Rules.

II. Definitions

3. In these Rules:

 a) "Commissioner" means the Honourable John Z. Vertes, who has been appointed to conduct the Inquiry pursuant to subsection 17(2) of the *Health Quality Council of Alberta Act;*

 b) "Commission" means the Public Inquiry into Health System Matters established by O.C. 80/2012;

 c) "Commission Counsel" means Dunphy Best Blocksom LLP, including the lawyers of that firm and its agents, if any;

 d) "Commission Offices" means the offices of the Commission located at:

 217, 811 – 14th Street N.W.
 Calgary, Alberta
 T2N 2A4

 e) "Intervener" means a person, group of persons or organization that has been granted standing by the Commissioner pursuant to the Commission's Policy on Standing;

 f) "Participant" means all Interveners and witnesses, and any other persons who are granted a right to make submissions or present or test evidence at the Inquiry;

g) "Record" includes a representation of any writing, picture, audio, video or data, howsoever recorded.

III. Investigation

4. Any person with knowledge, information or Records relevant and material to the Inquiry is encouraged to make such knowledge, information or Records known to the Commission or Commission Counsel at the earliest possible opportunity, including the names and addresses of any potential witnesses who may have knowledge or information relevant and material to the Commission's mandate.

Pre-Hearing Interviews

5. Commission Counsel may request that any person attend one or more interviews. Attendance at these interviews is voluntary. Any person interviewed by or on behalf of Commission Counsel is entitled to have counsel present for the interview. No right to financial assistance for counsel flows from this right to counsel.

Records

6. Any Participant who knows of the existence of any relevant Record or other evidence which may be relevant and material to the Commission's mandate must bring it to the attention of Commission Counsel at the earliest opportunity.

7. The Commission may serve any person or organization with a Notice to Produce Records in substantially the form attached to these Rules as **Schedule A**. Originals of relevant Records must be provided to the Commission upon request but otherwise copies of Records are sufficient.

8. With reference to sections 9 of the *Public Inquiries Act (Alberta)*, any Participant who possesses a Record which may be relevant and material to the Commission's mandate but believes that Record to be privileged will disclose the existence and description of that Record to Commission Counsel. If no agreement can be reached regarding the treatment of a Record over which privilege has been claimed, Commission Counsel may apply *in camera* to the

Commissioner for direction as to the admissibility of such a Record.

9. Unless and until a Record is marked as an exhibit in the public hearings, Commission Counsel will not use or disclose the Record for any purposes other than the purposes of the Inquiry. Commission Counsel will provide copies of Records to other Participants where it determines those Records are relevant to their interests on the condition that counsel for a Participant and the Participant itself/themselves provide to Commission Counsel a written undertaking in the form attached to these rules as **Schedule B**.

10. The Commissioner may, upon application, release any person in whole or in part from the provisions of his or her undertaking in respect of any particular Record(s).

11. In the event that the Commissioner so directs, counsel for a Participant must return to the Commission any or all Records provided to them by Commission Counsel including all copies made.

12. Any Participant can, prior to or during the public hearings before the Commissioner, apply to the Commissioner in writing for a direction that a particular Record be subject to a publication ban or other similar protections even if the Record becomes an exhibit at the public hearings.

IV. Public Hearings

13. The Commission is committed to a process of public hearings.

14. The Commission will set the dates, hours and locations of hearings and can amend those as required, on reasonable notice to all Participants.

15. Anything that detracts from proper decorum may be prohibited, and the Commissioner may exclude any person from the hearing room at any time in his discretion.

Notices to Attend

16. Commission Counsel may serve any person with a Notice to Attend at the Inquiry on reasonable notice for the purpose of

being questioned as a witness in substantially the form attached to these Rules as **Schedule C**.

17. The payment of any allowance for such attendance will be determined by Commission Counsel generally in accordance with the Alberta Rules of Court. If any person served with a Notice to Attend disagrees with the amount proposed by Commission Counsel, he or she or his or her counsel may apply to the Commissioner in writing to set the amount of such payment.

18. Any person served with a Notice to Attend must attend at the inquiry at the date, time and place specified by Commission Counsel to be questioned as a witness, and must bring to the inquiry any Records identified in the Notice to Attend which have not already been produced to Commission Counsel.

V. Evidence

19. The Commissioner is entitled to hear and rely on any evidence he considers to be required for the full investigation of the matters into which he has been appointed to inquire, whether or not that evidence would be admissible in a court of law. The strict rules of evidence do not apply at the Inquiry, although the rules of evidence may influence the Commissioner's weighing of evidence.

Witnesses

20. All questioning of witnesses will be under oath or affirmation and will be transcribed.

21. Commission Counsel will determine who will be called for questioning at the Inquiry, subject to Rule 22.

22. No person or Participant other than the Commissioner may compel the attendance of a witness. If Commission Counsel declines to call or to question a particular witness, any Participant may apply to the Commissioner for leave to do so. The application must include the name and address of the proposed witness, a summary of the anticipated evidence of the proposed witness, and copies of any documents which the applicant intends to have marked as exhibits during the questioning of the proposed witness.

23. If an application under Rule 22 is granted, the Commissioner may direct Commission Counsel to coordinate the attendance of the subject witness to be questioned at the Inquiry, including by directing Commission Counsel to serve the witness with a Notice to Attend and may impose any other conditions he deems fit upon the calling of such evidence.

Notice of Relevant Records

24. Commission Counsel will endeavor to provide reasonable notice to the witness' counsel and any Participants with an interest in the testimony of a particular witness of any Records that will likely be referred to during the course of a witness's testimony

25. Similarly, any Participant who is permitted to call or cross-examine a witness will endeavor to provide reasonable notice to Commission Counsel, witness' counsel and any Participants with an interest in the testimony of a particular witness of any Records they anticipate putting to the witness in the course of that witness's testimony.

Evidence Taken Outside the Public Hearings

26. Where it proves impractical or impossible to question a witness at a public hearing, Commission Counsel or any other person appointed by the Commissioner may question a witness other than at a public hearing, in which event, subject to the outcome of any application for evidence to be heard *in camera*, a transcript of the questioning will be made public within a reasonable time.

27. If a Participant wishes to cross-examine a witness whose evidence has been taken under Rule 26, that Participant may apply to the Commissioner for directions as to the conduct of that cross-examination.

In Camera Hearings

28. Any Participant may apply to the Commissioner for a determination that, in accordance with sections 18 and 19 of the *Health Quality Council of Alberta Act,* the hearing or a part of the hearing will be held *in camera.*

29. All transcripts of evidence taken *in camera* will be marked, both in hard copy and electronically as "Confidential" and will not be released, published or disclosed, by or to any person, although the Commissioner may still report on such evidence.

Order and Conduct of Questioning a Witness

30. Subject to an agreement with Commission Counsel or a contrary direction by the Commissioner, Commission Counsel will first adduce the evidence from the witness. Counsel for the witness may then examine the witness, followed by any Participants whose grant of standing allows a right of cross-examination. If they cannot agree on the order of cross-examination, the Commissioner will determine the order. Commission Counsel and counsel for the witness may reexamine the witness if appropriate at the conclusion of any cross-examination.

31. The Commissioner may, at his sole discretion, change the order of questioning for a witness.

32. Commission Counsel may question any witness with either leading or non-leading questions. Unless otherwise permitted by the Commissioner, all other Participants are limited in their questioning, including of their own witnesses, by the ordinary rules of evidence.

33. The Commissioner may require a witness to answer questions from the Commissioner, which the Commissioner deems to be relevant.

34. A witness may be questioned more than once throughout the course of the Inquiry.

35. A witness must answer all questions asked of him or her subject to the Commissioner sustaining an objection made by the witness's' counsel.

36. No Participant or counsel may speak to a witness about the witness's evidence while the witness is under oath or affirmation, except by leave of the Commissioner.

VI. Applications

37. Any Participant may seek a direction or determination from the Commissioner by making an application.

38. Any application must be made in writing at the earliest possible opportunity, and may be decided by the Commissioner based solely on the written record, without an oral hearing, unless an oral hearing is directed by the Commissioner. Even if the Commissioner elects to have an oral hearing, he may dispense with the public hearing of the application in his discretion.

39. Unless otherwise provided in these Rules or by the Commissioner, all applications and any supporting affidavits must be served on the offices of Commission Counsel and the Commission at least five days before presentation. The written application and any supporting affidavits must also be served on all Participants or their counsel, unless otherwise directed by the Commissioner.

40. The written application must outline the nature of the determination or direction that the applicant is seeking from the Commissioner and the grounds upon which the application is being made.

41. Subject to any terms or conditions on a Participant's standing or any direction by the Commissioner, any Participant may make submissions, or present or challenge the evidence, in response to an application brought by any other Participant.

VII. Judicial Review

42. Any application by a Participant or Commission Counsel for judicial review of a decision of the Commissioner made during the course of the public hearings will be brought before Chief Justice N. A. Wittmann of the Court of Queen's Bench or his designate.

43. Any notice of an application for judicial review and any supporting material must be filed and served upon Commission Counsel and any affected Participants within 5 days of the decision being challenged.

44. Any application for a stay of proceedings pending the hearing of an application for judicial review may be brought before either the Commissioner or Chief Justice N. A. Wittmann of the Court of Queen's Bench or his designate.

VIII. Access to Transcripts and Exhibits

45. All evidence entered as exhibits and all transcripts of the proceedings shall be identified and marked "P" for public sittings in numerical order and, if necessary, "C" for confidential exhibits or transcripts of *in camera* hearings for which non-disclosure, a non-publication or non-communication orders have been issued.

46. Copies of the final version of the "P" transcripts and exhibits will be posted on the Commission's website and will be available at the hearing room.

47. Only the Commissioner or Commission Counsel can authorize and give access to "C" transcripts and exhibits (under whatever conditions they determine necessary).

IX. Service

48. Unless otherwise provided in these Rules:

 a) service of any document or Notice may be effected on the Commission by e-mail, facsimile, courier or personal delivery provided that delivery is made to the Commission Offices and Commission Counsel; and

 b) service of any document or Notice may be effected on any Participant by e-mail, facsimile, courier or personal delivery to the Participant or to the Participants counsel, or in any manner directed by the Commissioner.

49. Materials may be served between 9:00 a.m. and 4:00 p.m. on weekdays, excepting holidays, and so serving is effective upon delivery of the materials. Service of materials outside of these dates and times will be deemed effective on the following weekday which is not a holiday.

The Honourable John Z. Vertes, Commissioner

SCHEDULE "A"

IN THE MATTER OF A PUBLIC INQUIRY INTO ALBERTA HEALTH SERVICES PREFERENTIAL ACCESS PURSUANT TO THE PUBLIC INQUIRIES ACT, R.S.A. 2000, c. P-39 AND THE HEALTH QUALITY COUNCIL OF ALBERTA ACT, c. H-7.2 (ORDER IN COUNCIL 80/2012)

NOTICE TO PRODUCE RECORDS

TO: _____

The terms of reference for this Public Inquiry (Order in Council 80/2012) are as follows:

1. Whether improper preferential access to publicly funded health services is occurring; and
2. If there is evidence of improper preferential access to publicly funded health services occurring, make recommendations to prevent improper access in the future.

Pursuant to section 17 of the *Health Quality Council of Alberta Act* and section 9 of the *Public Inquiries Act (Alberta)*, you are required, within ten (10) days of service of this notice on you or your solicitor, to produce to the office of Commission Counsel all records relevant and material to the issues in the Inquiry.

Dated this _____ day of _____, 2012.

The Honourable John Z. Vertes, Commissioner

CONTACT INFORMATION

Michele H. Hollins, Q.C.
Commission Counsel

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Barristers & Solicitors
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Calgary, AB, T2P 3R5
Telephone: (403) 750-1117
Facsimile: (403) 269-8911
Email: hollins@dbblaw.com

SCHEDULE "B"

IN THE MATTER OF A PUBLIC INQUIRY INTO ALBERTA HEALTH SERVICES PREFERENTIAL ACCESS PURSUANT TO THE PUBLIC INQUIRIES ACT, R.S.A. 2000, c. P-39 AND THE HEALTH QUALITY COUNCIL OF ALBERTA ACT, c. H-7.2 (ORDER IN COUNCIL 80/2012)

UNDERTAKING

I, _____ OF THE City of _____ in the Province of Alberta, hereby acknowledge and undertake to the Commission established by the Order in Council O.C. 8.2012, as follows:

I have been and/or will be provided with Records produced as part of the investigation and conduct of this Inquiry.

I hereby agree and undertake that I will not use or disclose any Record(s) so provided to me, other than for the purposes of my involvement in the Inquiry or that of my client. If I am counsel to a Participant, I undertake to obtain and provide to Commission Counsel a copy of this Undertaking signed by my client.

I understand that my failure to comply with the terms of this Undertaking may affect my ability to participate in the Inquiry and/or may attract other sanctions by the Commission.

DATED this ___ day of _____, 2012.

_____ _____

Witness Signatory

SCHEDULE "C"

IN THE MATTER OF A PUBLIC INQUIRY INTO ALBERTA HEALTH SERVICES PREFERENTIAL ACCESS PURSUANT TO THE PUBLIC INQUIRIES ACT, R.S.A. 2000, c. P-39 AND THE HEALTH QUALITY COUNCIL OF ALBERTA ACT, c. H-7.2 (ORDER IN COUNCIL 80/2012)

NOTICE TO ATTEND AS WITNESS AT HEARING

TO:

The terms of reference for this Public Inquiry (Order in Council 80/2012) (the "Inquiry") are as follows:

1. Whether improper preferential access to publicly funded health services is occurring; and
2. If there is evidence of improper preferential access to publicly funded health services occurring, make recommendations to prevent improper access in the future.

Pursuant to s.17 of the *Health Quality Council of Alberta Act* and s. 4 of the *Public Inquiries Act* (Alberta), this notice requires you to attend at a hearing before the Panel appointed to conduct the Inquiry and to testify. You must attend on December 3, 2012 or as directed by Commission Counsel and must bring with you any Records in your possession or control and which are relevant to the terms of reference of this Inquiry, unless otherwise directed by Commission Counsel.

An allowance will be paid to you for attending as a witness, the amount to be calculated by Commission Counsel in accordance with Schedule B, Division 3 of the Alberta Rules of Court.

Dated this ___ day of _____, 2012.

The Honourable John Z. Vertes, Commissioner

CONTACT INFORMATION

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(d) MEDIA POLICY

Message from the Executive Director

Journalists and other media representatives play an important role in the democratic process – providing the public with news and information about government initiatives and reporting on the views and opinions of all parties involved. The Health Services Preferential Access Inquiry wishes to establish a positive relationship with the media to promote public awareness and understanding of its Public Hearings process associated with the responsibility it has been given by the Government to investigate the serious allegations of preferential access to medical services in Alberta (commonly referred to as 'queue jumping'). To this end, rules and procedures have been proposed while ensuring that the participants engaged in the judicial process remain unimpeded in their work and responsibilities.

The Public Hearings will take place in Edmonton from December 3rd to 13th at the Shaw Convention Centre. The general public is invited to attend.

A tentative schedule of witnesses to appear at the Hearings will be released by the Inquiry on November 30th, 2012.

Sheila-Marie Cook, CVO
Executive Director

Media Contact

Samantha Beckett
Phone: 403-270-2059 ext. 110
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Email: sbeckett@abhealthinquiry.ca

MEDIA POLICY

The Commissioner has authorized the sound and visual recording of the public hearings.

A Media Centre will be established at the site of the public hearings and the Inquiry Media Staff will assist in providing these services to any duly accredited member of the media. Members will be asked to check into the Centre and present their credentials at the beginning of each day's hearings.

The Media Centre will be equipped with photocopying/fax facilities, wireless-internet, audio/visual feed services and access to the Inquiry's website which will feature a webcast of the proceedings for the public. In addition, copies of the daily transcripts and the registered exhibits will be made available for reference purposes within the Media Centre. Daily transcripts will be made available on the Inquiry's website within three hours of the closing of the hearings for the day. Remote visual coverage of the proceedings in the hearing room will be available on screens in the Centre.

- Cameras and microphones will be located at pre-determined places in the hearing rooms. Only fixed cameras and the fixed lighting system will be allowed.
- Copies of the recorded and visual proceedings will be made available at the end of each day to members of the media who have made prior arrangements with the Inquiry for this service.
- No media scrums, interviews, or reporting will be allowed in the hearing rooms or within the distance of ten (10) meters from the hearing room entrances.
- Should the Commissioner decide to proceed *in camera* or to issue a publication, disclosure or communication ban, the Inquiry Media Staff will take all necessary measures to ensure that all tape recording or sound recording machines have been turned off.
- Interview requests should be directed to the Inquiry Media Staff. Interviews will be conducted during breaks in the hearings. The Inquiry Media Staff will not schedule

interviews with Intervenors however, where possible, may direct the Media to the appropriate media representative for the parties.

The Use of Personal Electronic Devices in the Hearing Room

Any personal electronic device (PED) using cellular GSM-based or other wireless technology set so as to receive or transmit information, data or other signals via radio frequency, including mobile telephones, iPhones, BlackBerrys, Palm Treos, and portable computers, must, subject to the terms of this Notice, be turned off while the Inquiry is in session.

Notwithstanding the above, an individual user of such a PED who is a journalist from a recognized media organization may obtain permission in writing from the Inquiry to use the PED to "TWEET" or otherwise transmit digital information concerning the proceedings from within the hearing room in pursuance of the users' journalistic responsibilities.

Terms and Conditions

User will identify himself/herself and the PED to be used to Inquiry Media Staff upon entering the hearing room

- User will sit in the back three rows in the hearing room
- User will not use the audio capacity, including the sounds and signals, of the PED in the hearing room
- User will not take or create any photograph or video in the hearing room
- User will comply with any publication ban imposed by the Commissioner
- User will not transmit or disseminate information at all from the hearing room during the testimony of any person where so ordered by the Commissioner
- Use of PED by user will at all times be unobtrusive and silent and will not disrupt the proceedings or other persons or interfere with the digital recording system in the hearing room
- User undertakes to comply with any other direction from the Commissioner relating to the dissemination of information about the proceedings or the use of PEDs in the hearing room.

e(i) RULINGS ON STANDING AND FUNDING

IN THE MATTER OF A PUBLIC INQUIRY INTO ALLEGATIONS OF IMPROPER PREFERENTIAL ACCESS TO PUBLICLY FUNDED HEALTH SERVICES PURSUANT TO THE *HEALTH QUALITY COUNCIL OF ALBERTA ACT*, C. H-7.2 (ORDER-IN-COUNCIL 80/2012)

The Honourable John Z. Vertes, Commissioner

RULINGS ON STANDING AND FUNDING

I. INTRODUCTION

I have been appointed to conduct a public inquiry concerning the possibility of improper preferential access to publicly funded health services. The terms of reference, as set out by Order-in-Council 80/2012, issued on February 28, 2012, are to consider:

1. Whether improper preferential access to publicly funded health services is occurring; and
2. If there is evidence of improper preferential access to publicly funded health services occurring, make recommendations to prevent improper access in the future.

There will be two phases to this inquiry. The first will be a fact-finding inquiry to determine if improper preferential access is occurring. The second will be directed to policies and procedures that will assist in formulating recommendations to prevent such activities in the future.

The Order-in-Council also directed me to develop and submit to the Lieutenant Governor in Council a policy on whether assistance will be provided to witnesses or interveners to prepare submissions or for the costs of legal counsel.

Canadian jurisprudence, particularly with respect to commissions of inquiry, has recognized the importance of allowing interventions by parties who have a direct and substantial interest in the proceedings. This helps to ensure that an inquiry is able to fulfill its mandate by having before it all the relevant facts and circumstances. It also ensures

fairness, both procedurally and substantially. The jurisprudence also recognizes that funding may be necessary for those parties who establish an inability to meaningfully participate in the inquiry process without financial assistance. This too helps to ensure fairness.

This inquiry has been established under the provisions of the *Health Quality Council of Alberta Act*. Section 17(5) of that Act gives me the powers, privileges and immunities of a commissioner under the *Public Inquiries Act*. Neither statute expressly addresses grants of standing to interveners or the funding of witnesses and interveners. There are sections in both that require notice be given to persons who may be the subject of negative comment or findings and then those persons are to be given an opportunity to address the allegations (see Section 22(2) of the *Health Quality Council of Alberta Act* and Section 13 of the *Public Inquiries Act*). But whether this inquiry will be required to issue such a notice to any person is irrelevant to a grant of standing or funding. The purpose of such notices is simply to ensure that an inquiry complies with the principle of fairness. A public inquiry issues notice to the persons affected so that the recipients of such notice may provide a response to potential adverse findings.

With these principles in mind, I issued first a "Policy for Standing" that sets out the necessary criteria for a grant of standing and the procedure to be followed. In order to properly develop a policy on funding one has to know the basis on which a party may be given standing. That "Policy on Standing" sets out two criteria:

a) the applicant is or may be directly or substantially affected by the Inquiry; or

b) the applicant has or represents a clearly ascertainable interest or perspective, the representation of which ought to be separately represented at the Inquiry, and the representation of which will assist the Commissioner in fulfilling the mandate of the Inquiry.

A grant of standing will permit that party (called an "intervener") to participate in the inquiry, or parts of the inquiry, with the right to make submissions, the right to cross-examine witnesses, the right to advance notice of documents and the provision of evidence statements, the opportunity to suggest witnesses to be called by Commission counsel,

all subject to such terms and conditions as I may prescribe and the rules of procedure established for the inquiry.

I also issued a "Funding Policy" which was approved by Order-in-Council 264/2012 issued on July 25, 2012. The fundamental aim of that policy is to establish financial need as the primary consideration and then to balance that need along with the applicant's interest and anticipated contribution to the inquiry against the need to exercise care in the expenditure of public funds. The policy specifies that I may make a funding decision whether the funding wholly indemnifies the applicant or only partially and I may set conditions on the grant of funding.

The requirements that an applicant for funding must satisfy and the considerations that go into my decision are set out in the policy as follows:

1-6 An application for financial assistance must be supported by:

a) a sworn statutory declaration proving that the applicant does not have sufficient financial resources from any source to enable it to meaningfully participate in the Inquiry;

b) a written budget outlining the applicant's proposed involvement in the Inquiry and the estimated costs to be incurred by the applicant; and

c) a written proposal as to how the applicant will account for funds received.

1-7 In addition to the submissions of an applicant, the Commissioner will also consider other factors when deciding the application for financial assistance, including:

a) whether the applicant is a witness, an intervener or both;

b) in the case of applicants who are witnesses, whether the applicant's testimony is being compelled by Commission Counsel;

c) the nature and extent of the applicant's interest, including whether the applicant might be adversely affected by the report of the Commissioner;

d) whether the applicant has a demonstrated record of concern for and commitment to the interest it seeks to represent;

e) whether the applicant has special experience or expertise relevant to the Inquiry's mandate; and

f) whether the applicant could reasonably be included in a group with others of similar or overlapping interests.

The funding policy does not, and I do not in these rulings, address the question of payment of expert witnesses. The primary responsibility for calling any witness, including experts, lies with Commission Counsel. Experts called by Commission Counsel will be paid by this Commission. The funding policy is restricted to providing financial assistance to witnesses and interveners to prepare submissions or for the costs of legal counsel.

I also take the view that any funding decision be for a limited amount as opposed to open-ended funding on the basis of time spent. This will encourage efficiency and moderation. The policy also adopts the tariff on counsel fees set by the Government of Alberta for the retention of external counsel.

Finally, the funding policy enables me to make a "funding decision" but that decision must still be communicated to the Lieutenant Governor in Council with a request for the funding. This too accords with recent inquiries where the commissioner merely makes a recommendation to government for the funding of interveners. This is a reflection of the government's ultimate responsibility for the expenditure of public funds. But, of course, the public interest in a full, open and fair inquiry is a major consideration in the ultimate grant of funding by the government.

II. APPLICATIONS

This Commission announced its intention to hold public hearings into standing and funding applications when it issued the policies on those two subjects. A Notice was published and distributed inviting interested parties to apply by August 31, 2012. A further Notice was published setting out the time and place for the hearings, which were held in Edmonton on October 15 and 16, 2012.

I heard six (6) applications for standing, of which four (4) also applied for funding. I cannot comment on why there were not more applications but Commission Counsel did make contact with a large number of organizations that were thought to have an interest in the subject-matter of this inquiry.

The applicants, and my decision with respect to each, are as follows:

1. *Alberta Health Services:*

This applicant delivers and administers most of the publicly-funded hospital, health facility and community health services in Alberta. In light of its clear interest in the issues raised in the Order-in-Council, I am satisfied that Alberta Health Services meets the criteria for standing. It is not applying for funding.

This applicant will have participation rights as follows and subject to the following limitations:

a) the right to be present and represented by counsel throughout the inquiry;

b) the right to make submissions;

c) the right to receive advance disclosure of evidence to be called, and documents to be referred to, by Commission Counsel in accordance with the Commission's rules of procedure;

d) the right to suggest to Commission Counsel the names of witnesses that should be called or evidence that should be presented and, in the event of a dispute, to apply to me for directions;

e) the right to cross-examine witnesses, subject only to any agreement between counsel or my directions with respect to the cross-examination of expert witnesses.

These rights are to be read in accordance with and as complementary to the Commission's rules of procedure as promulgated from time to time and any directions from me as the Commissioner.

2. *Government of Alberta:*

The government, through the Ministry of Health, plays a key role in Alberta's health care system and has a direct interest in the subject-matter of this inquiry. It clearly meets the criteria for standing. It is not applying for funding.

The government will have standing and have the same participation rights as those previously set out for Alberta Health Services.

3. *Alberta Medical Association:*

The Alberta Medical Association applies for both standing and funding.

This Association represents over 11,000 Alberta physicians, medical residents and medical students and serves as an advocate for its physician members. In my opinion they clearly meet the criteria for standing and I so informed their counsel at the hearing.

Therefore, this Association will have the same participation rights as I outlined for Alberta Health Services.

With respect to funding, the Association filed a statutory declaration from its Executive Director stating that (i) the Association depends on membership dues to fund its activities; (ii) the funds required for legal assistance for this inquiry have not been budgeted for in its current budget and were not taken into account in setting this year's membership dues; (iii) funding assistance would allow the Association to continue funding existing programs as opposed to reducing expenditures; (iv) having to fully fund their legal expenses would prejudice other programs; and (v) the Association will incur additional in-house costs due to its participation in the inquiry. What this applicant did not do was either file a financial statement or be able to tell me, at the hearing, what their revenues and reserves were.

Subsequent to the hearing, the Association filed, on a confidential basis, its consolidated financial statements for the fiscal year ended September 30, 2011. In my opinion, having regard to the requirement in the funding policy for an applicant to establish it does not have sufficient financial resources to meaningfully participate in the inquiry, it would have been helpful to disclose this from the outset. What even a cursory examination of those statements reveals is that the

Association, in 2011, had a significant net revenue and has significant reserve funds. It has the resources to adequately fund its participation in this inquiry.

Therefore, the application for funding is denied.

4. *Consumers' Association of Canada (Alberta):*

This Association has applied for standing and funding.

The Association was incorporated in Alberta in 1978. It is a non-profit, non-partisan provincial association. It relies on donations and ad-hoc grants to carry out its work. Its mandate is to improve the quality of life by protecting and promoting consumer rights including health and safety. The Association has investigated various issues relating to the delivery of health services in Alberta and made recommendations to legislative committees and others. Its aim in participating in this inquiry is to make sure that the voice of the "consumer" of health services is incorporated in its work.

I think this Association can bring a valuable perspective to the inquiry's work, one different from that of health providers, government and professional organizations. Preferential access to health services can have an impact on all consumers of those services. I indicated at the hearing that I was not convinced that this organization needs full standing in all aspects of the inquiry to make its perspective known and to contribute to our work. I thought that perhaps the Association's contribution should be limited to the second phase of the inquiry's work, that being the formulation of recommendations to prevent the occurrence of such improper access.

On reflection I am satisfied, notwithstanding my earlier comments, that the Association should be granted standing for the entire inquiry. The nature and extent of this organization's interest with respect to health care relate to the broad consumer public interest, particularly in relation to access and patient safety. It could bring a different perspective to the consideration of fair and appropriate access to health care services. This applicant meets the policy criterion of representing a clearly ascertainable interest or perspective which ought to be separately represented and would assist this Commission in fulfilling its mandate.

Therefore, I grant standing to the Association with the same participation rights as I previously set out for Alberta Health Services.

With respect to the funding application, I am satisfied that the Association has no financial resources available to it so as to fund the services necessary for meaningful participation. The Association has a demonstrated record of concern and commitment for the interests of Alberta consumers. There is no group that has already been granted standing with which this organization could reasonably be included.

The Association has presented a budget anticipating full participation throughout the inquiry (an anticipated 20 days of hearings, preparation and research). It is not for me to second-guess the amount of research and preparation time that will be required but, as I noted previously, my funding decisions will not provide an open-ended financing but be capped at a maximum amount and all payments will only be for actual work done and reasonable disbursements incurred.

I therefore recommend a sum up to $120,000.00 as financial assistance to this Association. The funds will be used to pay accounts submitted by its counsel. Those accounts must include (a) the date the activity was undertaken; (b) a description of the activity undertaken; (c) the time incurred with respect to each service; and (d) the amount charged according to the tariff appended to the funding policy. The accounts are to be first approved by a duly-authorized board member of the Association and then submitted to the Commission's Executive Director who will also review and authorize them for payment.

5. *Project International Hope Institute for Human Rights:*

This organization filed an application for standing and funding. Its spokesperson, Dr. C. Paula van Nostrand, appeared at the hearing. This organization purports to speak for a network of volunteers who look after the various needs of people living in urban poverty. Their intent, as gleaned from their written submission, is to protect the interests of the disadvantaged and prevent the privatization of community health care.

It is undeniably the case that the voices of the poor, the disabled, and other marginalized groups, need to be heard in any discussion about the allocation of government resources and especially how health services are provided. But these issues are beyond the scope of this inquiry's

mandate. Improper preferential access may arise because of someone's influence or wealth, and that may have an impact on others waiting for health services, but this is a narrower scope, and a more focused one, than how the health system addresses the needs of the poor generally. Also, I have grave concerns that this is a self-created organization of one and that it lacks the credibility necessary to speak for a sizeable constituency within the community. There is no demonstrated and objective track record of its work.

For these reasons, I do not find that this organization meets the criteria for standing or funding. The application is denied.

6. *Renal Dialysis Rimbey Support Group:*

This applicant is a community-based, non-profit organization from Rimbey, Alberta. Its mission is to represent area residents who require renal dialysis and its goal is to bring a renal dialysis unit to the Rimbey General Hospital. Currently, patients have to go to Red Deer for dialysis treatments.

As I explained at the public hearing, it is not the mandate of this inquiry to examine the allocation of government resources. While I certainly sympathize with the concerns of this group I cannot make recommendations as to how government should allocate services, even essential services such as renal dialysis.

Therefore, I am not granting standing to this organization.

Nevertheless, this organization can bring a helpful perspective on the more general question of preferences in the health care system, and in particular, whether preferential access arises because of geographic distinctions, such as people living in urban areas having more readily accessible services than people living in rural areas. I therefore encourage this organization, as I did at the hearing, to prepare a written submission on this issue and the impact on its community. In order to assist this organization to do so, and since they have no sources of revenue, I have decided that this organization be granted financial assistance in a sum up to $5,000.00. This is in accordance with this inquiry's Funding Policy which provides that financial assistance may be provided for the purpose of preparing submissions. This amount is to be used to retain the services of a suitable individual (perhaps a graduate student in a relevant field of study) to assist in the preparation

of this submission. The name and professional qualifications of that individual are to be provided to the Commission's Executive Director and ultimately all invoices are to be submitted to the Executive Director.

III. CONCLUSION

I will be communicating to the Lieutenant Governor in Council, through the Minister of Health and Wellness, my decisions as to funding. I expect, however, that there may be further applications for standing and funding depending on the evidence that will be presented at the upcoming public hearings, especially if statutory notices are issued. I will address any such further applications if and when they are presented to me.

DATED this 19th day of October, 2012.

Honourable John Z. Vertes, Commissioner

Appearances:

Commission Counsel	Michele H. Hollins, Q.C. Jason L. Wilkins
Alberta Health Services	Brent F. Windwick, Q.C.
Government of Alberta	Vivian R. Stevenson, Q.C.
Alberta Medical Association	Jonathon P. Rossall, Q.C. Dr. William Hyndyk
Consumers Association of Canada (Alberta)	Deborah E. Prowse, Q.C.
Project International Hope Institute for Human Rights	Dr. C. Paula van Nostrand
Renal Dialysis Rimbey Support Group	Irene Kurta-Lovell Lorna Diggle

e(ii) RULING ON AN APPLICATION FOR FURTHER INTERVENER FUNDING

IN THE MATTER OF A PUBLIC INQUIRY INTO ALLEGATIONS OF IMPROPER PREFERENTIAL ACCESS TO PUBLICLY FUNDED HEALTH SERVICES PURSUANT TO THE *HEALTH QUALITY COUNCIL OF ALBERTA ACT*, C. H-7.2 (ORDER-IN-COUNCIL 80/2012)

The Honourable John Z. Vertes, Commissioner

RULING ON AN APPLICATION FOR FURTHER INTERVENER FUNDING

On October 19, 2012, I issued rulings respecting various applications for standing and funding pursuant to the policies established by this Commission and approved by a subsequent Order-in-Council. Among those rulings was the grant of standing to the Consumers' Association of Canada (Alberta). I also granted funding for Association for legal representation of up to $120,000.00. The Association has now made a request for additional funding.

When I made my initial rulings, the schedule for this inquiry anticipated four weeks of hearing evidence and an additional week for submissions. In January it became apparent that additional weeks would be required for the hearing of evidence. As a result, two further weeks were added to our schedule.

The original grant of funding to the Association was premised on the original schedule. With the addition of further weeks of hearing the budget initially proposed by the Association has proven to be inadequate to provide for the necessary legal representation. Without additional funding it cannot continue to participate meaningfully in this inquiry. As I stated in my earlier rulings, the Association has a demonstrated record of concern and commitment to the interests of Alberta consumers and it has, to date, played a helpful role in this inquiry. I am therefore satisfied that additional funding is appropriate.

The Association has provided a further detailed budget for the additional days of hearing. It is in my opinion a reasonable one that is within the parameters established by this inquiry's policies.

I am therefore granting to the Association additional funding up to the sum of $28,000.00. These funds, as before, will be used to pay the accounts submitted by legal counsel. The accounts must be in the form stipulated in my earlier ruling. The accounts are to be first approved by a duly-authorized board member of the Association and then submitted to the Commission's Executive-Director for review and authorization for payment.

DATED this 15th day of March, 2013.

Hon. John Z. Vertes

(f) OPENING STATEMENT

October 15, 2012

Today we begin the public proceedings of the Health Services Preferential Access Inquiry.

This inquiry was established by the cabinet's Order-in-Council issued on February 28, 2012. Section 17 of the *Health Quality Council of Alberta Act* provides that the Lieutenant-Governor in Council may order an inquiry into a matter relating to the health system and may direct the Board of the Health Quality Council to appoint a panel to conduct such an inquiry. On March 5, 2012, I was appointed as a one-person panel.

The Inquiry's terms of reference are two-fold:

1. To assess whether improper preferential access to publicly funded health services in Alberta is occurring; and
2. If there is evidence of improper preferential access to publicly funded health services occurring, to make recommendations to prevent such improper access in the future.

This Inquiry is independent of the government and independent of the Health Quality Council. My mandate is to examine the evidence, if there is evidence, relative to the terms of reference and to report my findings to the Speaker of the Legislative Assembly by April 30, 2013. As the panel for this inquiry, I will be guided only by the evidence and representations presented to me, in public, in the course of this inquiry, keeping in mind my over-arching responsibility to be fair and impartial.

I realize that there have been numerous complaints aired in the press and elsewhere to the effect that this inquiry's mandate is too narrow. That is not something for me to comment on. Let me simply say that I take the Premier at her word when she was quoted as saying that this inquiry can follow the evidence wherever it leads.

I should also note that this is the first inquiry ever to be held under the *Health Quality Council of Alberta Act*. This will explain some of the

delay in getting things started as administrative details had to be worked out so as to ensure the independence of this inquiry.

The background to this inquiry is well-known.

Allegations have been made that some individuals are being given, or have been given, preferential access to publicly funded health services in Alberta. This is commonly labeled "queue-jumping" in the media. Such a practice is improper and reprehensible. We all accept that access to publicly-funded health services should be based on patient need and the relative acuity of a patient's condition. It is improper to gain access to publicly funded health services through threat, influence or favour. It is in the public interest to assure our citizens that the publicly funded health care system enables Albertans to have fair and appropriate access to health services.

In 2002, the Honourable Roy Romanow issued his Royal Commission Report on the Future of Health Care in Canada. He wrote then that Canadians strongly support the core values of equity and fairness on which our health care system is premised. Canadians consider equal and timely access to medically necessary health care services on the basis of need as a right of citizenship, not a privilege of status or wealth. Allegations of improper preferential access strike at these values and that is why such allegations, if substantial, have to be investigated.

This Inquiry will be conducted in accordance with the statutory provisions contained in the *Health Quality Council of Alberta Act*. As the panel appointed to carry out this inquiry, I have the powers of a Commissioner under the *Public Inquiries Act*.

This Inquiry has broad powers of subpoena, but it is not a court of law. I cannot find individual fault. Indeed, Section 22 of the *Health Quality Council of Alberta Act* prohibits any findings of legal responsibility or any conclusions of law. What I can and must do is to find the facts and make recommendations.

I will now tell you a bit about myself and the senior staff who will be working with me. I am John Vertes, recently retired as the Senior Judge of the Supreme Court of the Northwest Territories. I was appointed in September, 1991 as a judge of the Supreme Court of the Northwest Territories as well as a justice of the Court of Appeal of

Yukon and Northwest Territories. In 1999, I was appointed to the Nunavut Court of Justice and the Nunavut Court of Appeal. I retired from the bench on July 1, 2011, and now live in Calgary.

The administrative management of this Commission will be the responsibility of Sheila-Marie Cook CVO, whom I have appointed to be Executive Director and Commission Secretary. Mrs. Cook is the former Deputy to the Governor General of Canada and also has extensive experience with major public inquiries and Royal Commissions. I am confident that everything related to our inquiry will be done in a timely and effective manner to support our hearings and the eventual production of our final report.

The Commission's lead counsel is Michele H. Hollins, Q.C., a partner in the firm of Dunphy Best Blocksom LLP in Calgary. Ms. Hollins has a varied civil and commercial litigation practice and extensive court room experience at all levels of Alberta Courts. Jason Wilkins, a partner of the same firm, will act as associate counsel for this inquiry. He has experience in mediations, both judicial and private, and advocacy experience at all levels of Court in Alberta, including significant trial and appellate work.

We are anxious to have input from Albertans who may have information to share on a confidential basis. The inquiry has established a website to enable individuals to submit such information during the fact-finding stage now underway. We are interested in anything that might support our investigation. It will be up to Commission Counsel to determine whether any of this information will be used in the public hearings. I am hopeful that this technology will allow Albertans, no matter where they may be located, to participate in this public process. Of course, they can also contact the Commission by telephone, fax or mail.

Today we are here to consider applications for standing and funding.

The Commission has adopted a policy regarding applications for standing. Essentially, any person or entity may apply for full or partial standing, which, if granted, permits them to participate in the hearings as an intervener. This term has no adversarial implications. Grants of standing may be subject to such terms and conditions as I consider appropriate.

My decisions regarding applications for standing will be based on two sets of criteria: First, whether the applicant is or may directly or substantially be affected by the Inquiry; and second, whether the applicant represents a clearly ascertainable interest or perspective which ought to be represented separately at this Inquiry and which will assist me in fulfilling the Inquiry's mandate.

This part of our hearings are only being held in Edmonton since all applicants are Edmonton-based. I did not think it prudent or cost-effective therefore to hold standing hearings in Calgary.

The Government approved a budget for this inquiry through an Order-in-Council on July 25, 2012, and accepted the Panel's Funding Policy for Witnesses and Interveners which is set out in Appendix 2 of that document.

Essentially, any witness or intervener can apply for funding for legal assistance. I have the authority to make a "funding decision" – that the applicant should receive financial assistance for the purpose of preparing submissions, or for the costs of legal counsel, to facilitate participation in the Inquiry.

If I decide that an applicant should receive funding then I will request those funds from cabinet.

I will also establish a set of rules governing practice and procedure for this public inquiry. The rules are designed to ensure fairness and efficiency in the inquiry process for the evidentiary part of these hearings, which will be held in Edmonton and Calgary in December and January.

To summarize these proposed rules without going into all the details, they provide, among other things, that:

1. All parties and witnesses have the right to counsel both at the Inquiry and at any pre-testimony interviews;
2. Commission counsel have the primary responsibility to call and question witnesses. Any party may apply to me for leave to have any witness called whom Commission counsel elects not to call;

3. Each witness and party shall be provided with copies, in paper or electronic form, of documents and evidence which are relevant to the party's or witness' interest, to the extent it is appropriate to do so, together with the documents which Commission counsel expects to put to him or her in the course of his or her testimony, and will have the right to introduce their own documentary evidence;
4. All hearings will be held in public unless an application is granted for a publication ban or for a portion of the hearing to be held *in camera* in conformity with the statutory provisions that apply;
5. Parties are encouraged to provide to Commission counsel the names and addresses of all witnesses they feel ought to be heard, and to provide all relevant documents, at the earliest opportunity;
6. Although evidence may be presented that might not ordinarily be admissible in a court of law, I shall be mindful of the danger of admitting such evidence and, in particular, its possible effect on someone's reputation.

Transcripts of each day's testimony and copies of filed exhibits will be posted on the Commission website.

I urge all interested parties and their counsel to read the rules once they are finalized and become familiar with them. To the extent that all participants in this important public process adhere to the rules, the process will be more efficient and the Commission's work will be done more effectively.

I have also promulgated a media policy and I encourage members of the press to review that with my Executive Director. I am committed to an open and transparent process so the co-operation of the media will be vital.

The work that lies ahead is most challenging and of great importance to the citizens of Alberta as well as to the integrity of our health care system. I have been entrusted to oversee this process and to ensure that the Commission's work is thorough and results in meaningful recommendations. I am confident that the administrative and legal aspects will be handled with skill and efficiency by the team I have

assembled. I look to all participants for their cooperation and dedication so that, at the end of this process, the public will be satisfied that the issues have received a full and fair examination.

(g) EXHIBIT LIST

In the Matter of the HEALTH SERVICES PREFERENTIAL ACCESS INQUIRY, by Order in Council, dated February 28, 2012.

The inquiry proceeding under sections 17 and 22 of the *Health Quality Council of Alberta Act*

Before The Hon. J.Z. Vertes, Commissioner of the Health Services Preferential Access Inquiry

INQUIRY EXHIBIT LIST					
Date	**Exhibit #**	**Description**	**Submitting Party**	**Triage#**	**Notes**
October 15, 2012	1	Order in Council – February 28, 2012	**Commission** Counsel	EXH-001-000001	4 pages
	2	Order in Council - July 25, 2012	**Commission** Counsel	EXH-001-000005	4 pages
	3	Letter – August 31, 2012	Alberta Health **Services**	EXH-001-000009	2 pages
	4	Letter – August 31, 2012	Government of Alberta	EXH-001-000011	4 pages
	5	Letter – September 30, 2012	Alberta Medical **Association**	EXH-001-000015	6 pages
	6	Statutory Declaration – M Gormley	Alberta Medical **Association**	EXH-001-000021	6 pages
	7	Letter – October 13, 2012	Alberta **Consumers Association**	EXH-001-000027	1 page
	8	Application – October 14, 2012	Alberta **Consumers Association**	EXH-001-000028	7 pages
	9	Package of Documents	Project Hope – Dr. van Nostrand	EXH-001-000035	19 pages
October 16, 2012	10	Package of Documents	Renal Dialysis of Rimbey	EXH-001-000054	20 pages
December 3, 2012	11	Report of Professor William Lahey,	**Commiss1ion** Counsel	EXH-001-000074	Red Binder, (65 pages)
	12	Report of J.L. Saunders	**Commission** Counsel	EXH-001-000139	White Binder, (148 pqes)
December 4, 2012	13	Curriculum Vitae of D.W. Megran	**Commission** Counsel	EXH-001-000287	31 pages
	14	"Request for Preferential or Expedited Care" by D.W. Megran	**Commission** Counsel	EXH-001-000318	May 10, 2009 (1 page)
	15	Email from Megran to Ducket	**Commission** Counsel	EXH-001-000319	May 10, 2009, (5 pages)
	16	Memo from Ducket to Executives	**Commission** Counsel	EXH-001-000321	June 11, 2009, (2 pages)
	17	Email from J. Robinson to D.W. Megran (re: Caritas Policy)	**Commission** Counsel	EXH-001-000323	June 16, 2009 (10 pages)
	18	Draft Policy "Request for Preferential or Expedited Care"	**Commission** Counsel	EXH-001-000333	November 30, 2012 (3 pages)

Exhibit List

In the Matter of the HEALTH SERVICES PREFERENTIAL ACCESS INQUIRY, by Order in Council, dated February 28, 2012.

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INQUIRY EXHIBIT LIST

Date	Exhibit #	Description	Submitting Party	Triage#	Notes
	19	**Curriculum Vitae of Stephen Ducket**	**Commission Counsel**	EXH-001-000336	15 pages
	19A	Procedural Order #1: Video Conferencing Testimony Dr. Ducket	**Commission Counsel**		1 page
	20	**Minutes of Meeting, Chief Executive** Officer Report	**Commission Counsel**	EXH-001-000351	May 2009, (6 pages)
	21	Ducket speech	**Commission Counsel**	EXH-001-000357	Dec 6, 2010 (2 pages)
	22	Ducket speech	**Commission Counsel**	EXH-001-000359	May, 2011 (1 page)
December 5, 2012	23	**Emergency Admission Flow Chart**	**Commission Counsel**	EXH-001-000360	2 pages
	24	**Curriculum Vitae Paul Parks**	**Commission Counsel**	EXH-001-000362	6 pages
	25	Letter from B. Holroyd to D. **Gordon and K. Gardener**	**Commission Counsel**	EXH-001-000368	"Paul Parks" letter, (6 pages)
	26	**Curriculum Vitae of Brian Holroyd**	**Commission Counsel**	EXH-001-000374	35 pages
	27	Letter from B. Holroyd to D. **Gordon** and D. Taylor	**Commission Counsel**	EXH-001-000409	With **addresses,** Dec 5, 2007, (5 pages)
December 6, 2012	28	**Resume of David S. Diamond**	**Commission Counsel**	EXH-001-000414	2 pages
	29	**Curriculum Vitae of D. Gordon**	**Commission Counsel**	EXH-001-000416	7 pages
December 10, 2012	30	Resume of Kathy Taylor	**Commission Counsel**	EXH-001-000423	2 pages
	31	**Resume of Donald Christensen**	**Commission Counsel**	EXH-001-000425	3 pages
	32	**Memo from D. Christensen to Nicole Farago**	**Commission Counsel**	EXH-001-000428	October 11, 2012 (1 page)
December 11, 2012	33	Hansard Excerpt March 17, 2009	**Commission Counsel**	EXH-001-000429	1 page
	34	November 3, 2009 email to K. King	**Commission Counsel**	EXH-001-000430	1 page
	35	November 3, 2009 email from Caloary West to Health Minister	**Commission Counsel**	EXH-001-000431	1 page
	36	Letter to Hon. Ron Liepert, (fax date on top November 3, 2009)	**Commission Counsel**	EXH-001-000432	1 page
	37	AR77491 Action Request November 20,2009	**Commission Counsel**	EXH-001-000433	1 page

In the Matter of the HEALTH SERVICES PREFERENTIAL ACCESS INQUIRY, by Order in Council, dated February 28, 2012.

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INQUIRY EXHIBIT LIST

Date	Exhibit #	Description	Submitting Party	Triage#	Notes
	38	AR77708 Action Request December 10, 2009	**Commission** Counsel	EXH-001-000434	1 page
	39	Resume of Ms. Patty Grier	**Commission** Counsel	EXH-001-000435	2 pages
	40	Professional Experience (Resume) of Lynn Redford	**Commission** Counsel	EXH-001-000437	1 page
	41	Email from Debbie Korzeniewski	**Commission** Counsel	EXH-001-000438	1 page
December 13, **2012**	42	Caritas Health Group Act (June 26, 1992i	**Commission** Counsel	EXH-001-000439	3 pages
	43	Bill Pr2 (Caritas H.G. Statutes Amendments Act-2009)	**Commission** Counsel	EXH-001-000442	13 pages
	44	Patient Care Manual Procedure	**Commission** Counsel	EXH-001-000455	2 pages
	45	Patient Care Manual Policy	**Commission** Counsel	EXH-001-000457	7 pages
	46	Mission Discernment Case Study 5 – Accommodating Special Requests (VIP treatment)	**Commission** Counsel	EXH-001-000464	1 page
	47	Memo from Patrick Dumelie to Caritas Managers and Physician Leaders	**Commission** Counsel	EXH-001-000465	October 1, 2007, (2 paqes)
	48	Covenant Health – Accommodating Special Requests (Corporate Policy & Procedures Manual)	**Commission** Counsel	EXH-001-000467	7 pages
	49	Patient Care Manual Policy – Request for Specific Gender of Healthcare Provider	**Commission** Counsel	EXH-001-000474	2 pages
	50	Patient Care Manual Procedure – Request for Specific Gender of Healthcare Provider	**Commission** Counsel	EXH-001-000476	4 pages
	51	Mission Discernment Case Study 4 – Patient requests for specific health **care provider**	**Commission** Counsel	EXH-001-000480	1 page
	52	Patient Request for Specific Health Care Provider – Corporate Policy & Procedures Manual	**Commission** Counsel	EXH-001-000481	2 pages
	53	December 5, 2007 letter from Dr. Holroyd to D. Gordon and D. Taylor	**Commission** Counsel	EXH-001-000483	5 pages
	54	Email from Dennis Laughlin to Edmonton Meadowlark (June 8, 2011)	**Commission** Counsel	EXH-001-000488	1 page
	55	Letter to Ethics Commissioner Legislative Assembly (June 10, 2011)	**Commission** Counsel	EXH-001-000489	2 pages

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Before The Hon. J.Z. Vertes, Commissioner of the Health Services Preferential Access Inquiry

INQUIRY EXHIBIT LIST					
Date	**Exhibit #**	**Description**	**Submitting Party**	**Triage#**	**Notes**
	56	Email from Paul Parks (October 16, 2012)	**Commission Counsel**	EXH-001-000491	3 pages
	57	**Portion of Power Point presentation** "Alberta's Health Legislation: Moving **Forward"**	**Commission Counsel**	EXH-001-000494	**Cover**, slide 23 and 24, (3 pages)
	58	Email from Raj Sherman to Shelia Weatherill (February 22, 2008)	**Commission Counsel**	EXH-001-000497	2 pages
	59	**CTV Edmonton Interview transcript** (June 7, 2011)	**Commission Counsel**	EXH-001-000499	2 pages
	60	**CBC Interview⇓No hospital wait for** "buddies" (June 7, 2011)	**Commission Counsel**	EXH-001-000501	2 pages
	61	Letter to Steve Sabey (September 30, 2010)	Counsel - Raj **Sherman**	EXH-001-000503	10 pages
	62	Letter dated September 13, 2010 from Kim Shulha to Dr. Sherman	Counsel - Raj **Sherman**	EXH-001-000513	4 pages
	63	**Letter to Premier Alison Redford** (November 3, 2011) from opposition **leaders**	Counsel - Raj **Sherman**	EXH-001-000517	2 pages
	64	Letter to D/Comm. McGowan RCMP (June 7, 2011)	**Commission Counsel**	EXH-001-000519	1 page
	65	**Interoffice Memorandum to B. Mason from R. Liebrecht** (10/09/2012)	**Commission Counsel**	EXH-001-000520	2 pages
January 7, 2013	66	Hansard Excerpt from April 8, 2009	**Commission Counsel**	EXH-001-000522	2 pages
	67	**Procedural Order #2: Witness Statement of Lori Jobson**	**Commission Counsel**	EXH-001-000525	1 page
	68	**Witness Statement of Lori Jobson**	**Commission Counsel**	EXH-001-000526	Note: typo **for sworn** date, sb 2013. (1 page)
	69	**Curriculum Vitae: Shelia Weatherill**	**Commission Counsel**	EXH-001-000528	3 pages
January 10, 2013	70	**Curriculum Vitae: Dr. Nicholas G.H.** Mohtadi	**Commission Counsel**	EXH-001-000531	46 pages
	71	Surgical Booking Request: AHS	**Commission Counsel**	EXH-001-000577	1 page
	72	**The Referral Consultation Process** Standard 6	**Commission Counsel**	EXH-001-000579	3 pages
	73	Alberta Netcare Website Excerpt	**Commission Counsel**	EXH-001-000582	5 pages
	74	**Physician Patient Relationship:** Establishing the Physician Patient **Relationship in Office Based** Settings: Standard 7	**Commission Counsel**	EXH-001-000587	duplicate exhibit #122 (3 pages)

In the Matter of the HEALTH SERVICES PREFERENTIAL ACCESS INQUIRY, by Order in Council, dated February 28, 2012.

The inquiry proceeding under sections 17 and 22 of the *Health Quality Council of Alberta Act*

Before The Hon. J.Z. Vertes, Commissioner of the Health Services Preferential Access Inquiry

INQUIRY EXHIBIT LIST

Date	Exhibit #	Description	Submitting Party	Triage#	Notes
	75	Quality of Life Assessment in Anterior Cruciate Ligament Deficiency	**Commission** Counsel	EXH-001-000590	5 pages
	76	Quality of Life Assessment in Rotator Cuff Patients	**Commission** Counsel	EXH-001-000595	10 pages
	77	Hip – QOL: Quality of Life Questionnaire for Young Active Patients with Hip Problems	**Commission** Counsel	EXH-001-000605	6 pages
	78	Curriculum Vitae of William (Bill) Anderson M.D.	**Commission** Counsel	EXH-001-000611	2 pages
	79	News Article Global Edmonton, July 12, 2011 (re: Paula Findlay)	**Commission** Counsel	EXH-001-000613	3 pages
	80	Email from July 12, 2011 to Edmonton Mill Creek (GOV-001-0210)	**Commission** Counsel	EXH-001-000616	1 page
	81	Email from July 13, 2011 to Stoney Plain (GOV-001-0212)	**Commission** Counsel	EXH-001-000617	1 page
	82	Biographical Notes Neil R. Wilkinson	**Commission** Counsel	EXH-001-000618	1 page
January 11, 2013	83	Curriculum Vitae of Dr. James Thorne	**Commission** Counsel	EXH-001-000619	2 pages
	84	Letter to Dr. Trevor Theman from Dr. D. Megran (Nov 6, 2009)	**Commission** Counsel	EXH-001-000621	2 pages
	85	Letter to Dr. D. Megran from Dr. Karen Mazurek (Dec 21, 2009)	**Commission** Counsel	EXH-001-000623	3 pages
	86	Media Statement – November 4, 2009: AHS H1N1/Flames	**Commission** Counsel	EXH-001-000626	1 page
	87	Alberta Legislative Hansard – November 29, 2010	Government of Alberta	EXH-001-000627	16 pages
January 14, 2013	88	Resume of Lori Anderson	**Commission** Counsel	EXH-001-000643	3 pages
	89	Investigation Summary – November 4, 2009 (Re: Calgary Flames H1N1)	**Commission** Counsel	EXH-001-000646	3 pages
January 15, 2013	90	Referral Form from Colon Cancer Screening Centre	**Commission** Counsel	EXH-001-000649	1 page
	91	CCSC data base spread sheet	**Commission** Counsel	EXH-001-000650	7 pages
	92	CCSC referral sheet (#10)	**Commission** Counsel	EXH-001-000657	1 page
	93	CCSC referral form (#11)	**Commission** Counsel	EXH-001-000659	1 page
	94	CCSC referral form (#2)	**Commission** Counsel	EXH-001-000660	1 page
	95	CCSC referral form (#17)	**Commission** Counsel	EXH-001-000661	1 page
	96	CCSC referral form (#9)	**Commission** Counsel	EXH-001-000662	1 page

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INQUIRY EXHIBIT LIST

Date	Exhibit #	Description	Submitting Party	Triage#	Notes
	97	CCSC referral form (#15)	Commission Counsel	EXH-001-000663	1 page
	98	CCSC referral form (#7)	Commission Counsel	EXH-001-000664	1 page
	99	CCSC referral form (#18)	Commission Counsel	EXH-001-000665	1 page
	100	CCSC referral form (#12)	Commission Counsel	EXH-001-000666	1 page
	101	CCSC referral forms (#1,3,4,5,8 [2pgs],14,16)	Commission Counsel	EXH-001-000667	8 pages
	102	**Sworn statement of Shelia Weatherill**	Commission Counsel	EXH-001-000675	1 page
IN CAMERA APPLICATION EXHIBIT	A	Letter dated November 22, 2013	Commission Counsel	Confidential	
IN CAMERA APPLICATION EXHIBIT	B	Letter dated January 13, 2013	Commission Counsel	Confidential	
January 16, 2013	103	New for 2008, Clinical Practice **Guideline: Screening for Colorectal Cancer**	Commission Counsel	EXH-001-000676	18 pages
	104	CCSC Reporting structure **Organization chart**	Commission Counsel	EXH-001-000693	1 page
	105	CCSC Referral, triage and Pre-**Assessment Departmental Procedure**	Commission Counsel	EXH-001-000694	6 pages
	106	⇓**Referral Received" organization** flow chart (black and white)	Commission Counsel	EXH-001-000699	1 page
	107	Forzani & MacPhail CCSC "Triage **Clerk picks up.." organization flow** chart (color)	Commission Counsel	EXH-001-000700	1 page
	108	AHS CCSC: Department Policy: **Endoscopist Responsibilities at the Centre**	Commission Counsel	EXH-001-000701	5 pages
	109	**Documents: FW: Concerns over** endoscopy que jumping – CCSC policy on the subject	Commission Counsel	EXH-001-000706	4 pages
	110	**Email from Joanne Zinter to Alaa** Rostom, June 17, 2011	Commission Counsel	EXH-001-000709	1 page
	111	Letter, February 3, 2012 From Joanne Zinter (addressee redacted).	Commission Counsel	EXH-001-000710	2 pages
	112	**Email: Re: Concerns over** endoscopy que jumping – CCSC **policy on the subject- from Shawna** Syverson	Commission Counsel	EXH-001-000712	1 page
January 17, 2013	113	Email from Linda Duffley to CHS Influenza Site Leads – October 31, 2009	Commission Counsel	EXH-001-000713	1 page

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INQUIRY EXHIBIT LIST

Date	Exhibit #	Description	Submitting Party	Triage#	Notes
	114	AHS Memorandum – January 25, 2010 from Linda Duffley	**Commission** Counsel	EXH-001-000714	1 page
	115	Letter received December 31, 2009	**Commission** Counsel	EXH-001-000715	1 page
	116	Reporting form (Daily) for Pandemic H1N1 2009 Influenza vaccine	**Commission** Counsel	EXH-001-000716	2 pages
	117	Edmonton Zone, H1N1/Seasonal Influenza/Pneumococcal Immunization 2009/2010 spreadsheets	**Commission** Counsel	EXH-001-000718	2 pages
January 18, 2013	118	CMA Policy: CMA Code of Ethics	**Commission** Counsel	EXH-001-000720	4 pages
	119	Letter to Dr. Max Findlay from Ms. Dawn Sunde (July 20, 2011)	**Commission** Counsel	EXH-001-000724	1 page
	120	Letter to Ms. Dawn Sunde from Dr. Max Findlay (August 3, 2011)	**Commission** Counsel	EXH-001-000725	1 page
	121	Memorandum to Dr. Karen Mazurek from Ms. Dawn Sunde (August 11, 2011)	**Commission** Counsel	EXH-001-000726	1 page
	122	Establishing the Physician Patient relationship in Office Based Settings Standard #7	**Commission** Counsel	EXH-001-000727	Duplicate exhibit #74 (2 pages)
	123	Charging for Uninsured Medical Services Standard 18	**Commission** Counsel	EXH-001-000729	1 page
	124	Email from Karen Mazurek sent May 01, 2012 to (redacted) cc'd Ken Gardener	**Commission** Counsel	EXH-001-000730	1 page
	125	Conflict of Interest Involving Financial or Personal gain by Physicians standard 29	Ms. Prowse Q.C	EXH-001-000732	2 pages
	126	Ms. Rita Nieman application and documentation	**Commission** Counsel	EXH-001-000734	8 pages
	127	fax cover to Dr. Love from Dr. Caine with referral forms, billing sheet and booking notes	**Commission** Counsel	EXH-001-000742	4 pages
	128	GI Central Triage Status – August 2010 and Roles in GI Central Triage	**Commission** Counsel	EXH-001-000746	6 pages
	129	Letter (referral package) from Dr. Caine to Dr. Bridges (October 26, 2010)	**Commission** Counsel	EXH-001-000752	10 pages
	130	photocopy of Dr. Boswell notes (March 22, 2010)	**Commission** Counsel	EXH-001-000762	7 pages
February 20, **2013**	131	Email from R. Bridges to Olga Koch and Darlene Pontifex (January 4, 2011)	**Commission** Counsel	EXH-001-000769	1 page
	132	Email from R. Bridges to Olga Koch and cc'd to Darlene Pontifex (January 4, 2011)	**Commission** Counsel	EXH-001-000770	1 page

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INQUIRY EXHIBIT LIST					
Date	**Exhibit #**	**Description**	**Submitting Party**	**Triage#**	**Notes**
	133	Email from R. Bridges to Olga Koch **and Darlene Pontifex and Alaa** Rostom (December 16, 2011)	**Commission Counsel**	EXH-001-000771	1 page
	134	**Copy of one page of notes**, November 22, 2010	**Commission Counsel**	EXH-001-000772	1 page
	135	**Curriculum Vitae Dr. R. Bridges**	**Commission Counsel**	EXH-001-000773	26 pages
February 25, 2013	136	Email dated Januar y 18, 2012 From R. Bridges cc; Olga Koch (2pg)	**Commission Counsel**	EXH-001-000799	2 pages
	137	Email dated December 16, 2011, From R. Bridges cc; Olga Koch	**Commission Counsel**	EXH-001-000801	1 page
	138	AHS Medical Staff By-laws (excerpt)	Mr. David Steele	EXH-001-000802	7 pages
	139	**Blank Individual Service Agreement forms**	**Commission Counsel**	EXH-001-000809	2 pages
	140	**Letter To Francois Belanger From** Dr. Mark Swain dated **February** 17, 2013	**Commission Counsel**	EXH-001-000811	3 pages
	141	Appendix 1: GI Chart Review February 17, 2013	**Commission Counsel**	EXH-001-000814	17 pages
	142	Clinical Tally Sheets for 2011	**Commission Counsel**	EXH-001-000830	6 pages
	143	**Individual Service Agreement, Dr.** Bridges	**Commission Counsel**	EXH-001-000836	3 pages
	144	**Recommendation for Administrative** Appointment (December 6, 2012)	**Commission Counsel**	EXH-001-000839	1 page
	145	**Set of emails from Helios to Bridges**	**Commission Counsel**	EXH-001-000840	18 pages
	146	Minutes of April 2, 2012 Faculty of **Medicine Leadership Forum**	**Commission Counsel**	EXH-001-000858	3 pages
February 26, 2013	147	Ethics in Radiology: Wait Lists Queue Jumping	Alberta Hea lth **Services**	EXH-001-000861	6 pages
	148	Do As I say, Not As I Do: a survey of **public impressions of queue jumping and preferential access**	Alberta Hea lth **Services**	EXH-001-000867	5 pages
	149	**Bound document containing Curriculum Vitae and reports of all** panel participants (for both days of panel hearinos)	**Commission Counsel**	EXH-001-000872	183 pages
	150	Nationa l Post Article: Top Doctor Admits to Queue--ump	Alberta Hea lth **Services**	EXH-001-001050	2 pages
	151	"Alter Article"- A Survey of Provider **Experiences and Preceptions..** ."	Alberta Hea lth **Services**	EXH-001-001052	6 pages
	152	Renal Dialysis Rimbey Support Group Application Report	**Commission Counsel**	EXH-001-001058	24 pages
	153	**Response to Renal Dialysis Rimbey** Support Group Application and Report	Alberta Hea lth **Services**	EXH-001-001082	7 pages

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INQUIRY EXHIBIT LIST

Date	Exhibit #	Description	Submitting Party	Triage#	Notes
February 28, 2013	154	Sworn Statement of Heather Stubley	**Commission Counsel**	EXH-001-001088	2 pages
	155	**Package of documents pertaining to Helios Wellness Centers**	**Commission Counsel**	EXH-001-001090	24 pages
	156	**Statutory Declaration of Dr. Terry Sosnowski**	**Commission Counsel**	EXH-001-001114	1 page
	157	Affidavit of Monica Ulmer	**Commission Counsel**	EXH-001-001115	11 pages
	158	**Statutory Declaration of Ms. Jennifer Currie**	**Commission Counsel**	EXH-001-001127	2 pages
April 4, 2013	159	**Helios Wine List**	**Commission Counsel**	Not loaded into Triage as of April 3, 2013	1 page
	160	**Letter from Shannon Wray, March** 27, 2013 re: Helios Donors	**Commission Counsel**	Not loaded into Triage as of April 3, 2013	1 page
	161	**Statutory Declaration of Leahann McElveen**	**Commission Counsel**	Not loaded into Triage as of April 3, 2013	16 pages
	162	Statutory Declaration of Lee Tkaczyk	**Commission Counsel**	Not loaded into Triage as of April 3, 2013	2 pages
	163	**Written submissions of Commission Counsel**	**Commission Counsel**	Not loaded into Triage as of April 3, 2013	83 pages
	164	**Written Submissions for Alberta Health Services**	**Brent Windwick,** QC	Not loaded into Triage as of April 3, 2013	26 pages
	165	**Written Submissions for Alberta Medical Association**	Jonathan P. Rossall, Q.C	Not loaded into Triage as of April 3, 2013	17 pages
	166	**Written Submissions for Government** of Alberta	**Vivian R. Stevenson, Q.C.**	Not loaded into Triage as of April 3, 2013	56 pages
	167	**Written Submissions for The Consumers Association of Alberta**	Deborah Prowse, Q.C	Not loaded into Triage as of April 3, 2013	21 pages
	168	**Written Submissions for Dr.** Max Findla y	**Simon Johnson**	Not loaded into Triage as of April 3, 2013	4 pages
	169	**Written Submissions for Dr. Rostom** and Dr. Bridges	David Steele	Not loaded into Triage as of April 3, 2013	17 pages
	170	**Written Submissions for Sheila** Weatherill	Mona T. Duckett, Q.C.	Not loaded into Triage as of April 3, 2013	22 pages

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INQUIRY EXHIBIT LIST

Date	Exhibit #	Description	Submitting Party	Triage#	Notes
	171	Written Submissions for Helios Wellness Centre	Shannon Wray	Not loaded into Triage as of April 3, 2013	19 pages
	172	Written Submissions for College of Physicians and Surgeons of Alberta	Craig Boyer	Not loaded into Triage as of April 3, 2013	278 pages
				Total pages:	**1699**

HEALTH SERVICES PREFERENTIAL ACCESS INQUIRY

ALBERTA



VOLUME 2: RESEARCH AND EXPERT OPINIONS

Health Services Preferential Access Inquiry – Alberta

The Hon. John Z. Vertes, Commissioner

Volume 2: Research and Expert Opinions

August 2013

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Introduction

This research volume contains the reports and papers commissioned by the inquiry to help inform its work. The first section contains the expert reports of Professor William Lahey and Mr. J.L. Saunders. These reports provided the background for their expert testimony on December 3, 2012. The reports were entered as exhibits 11 (Lahey) and 12 (Saunders) at inquiry hearings.

Professor Lahey's report, *The Legislative Framework Governing Access to Health Services that are "Insured Health Services" under the* Canada Health Act *and "Insured Services" under the Legislation of Alberta*, examines federal and provincial laws governing health care in Canada. Mr. Saunders' report, *How Healthcare is Delivered in Alberta*, reviews the organization of health care services in Alberta. Mr. Saunders' report is reproduced without the substantial appendices that were attached to his original report. Readers can see these appendices by examining exhibit 12 online.

The second section of this volume contains the research papers produced by six experts who testified on February 26 and 27, 2013. These papers are assembled in a single document marked exhibit 149. The papers respond to seven questions posed to each expert by the inquiry research branch. The seven questions are as follows:

1. What is "preferential access" to health care?
 a. Is there a common definition?
2. Is there a difference between "proper preferential access" and "improper preferential access"?
3. In your opinion, what would be examples of "proper" preferential access to health care?
 a. Is there harm to the public care system associated with "proper" preferential access to health care?
 b. In your opinion, what is the nature of that harm?
 c. Is that harm acceptable from an ethical or practical perspective?

4. In your opinion, what would be examples of "improper" preferential access to health care?
 a. Is there harm to the public care system associated with "improper" preferential access to health care?
 b. In your opinion, what is the nature of that harm?
 c. Is that harm acceptable from an ethical or practical perspective?

5. Which of the following would you characterize as "proper" or "improper" access to health care and why?
 a. Physician advocacy.
 b. Physician use of emergency OR [Operating Room] slots to book patients for surgeries.
 c. Allowing a physician or hospital worker to obtain an MRI faster than spending time on the waiting list.
 d. Hospital or medical staff obtaining flu shots before the general public.
 e. Professional athletes and their families obtaining flu shots or medical treatment before the general public.
 f. A physician arranging for a friend or family member to be seen quickly.
 g. Politicians/donors/philanthropists being seen in emergency without waiting (depending on the nature of the problem).

6. Are you aware of any safeguards which currently exist in the health care system to prevent "improper" preferential access?
 a. If so, do you believe such safeguards to be effective, and why?

7. Do you believe that there are changes that can be made to the existing health care system to avoid or prevent improper preferential access?
 a. What changes would you recommend, and why?

A literature review performed by Dr. Nishan Sharma of the University of Calgary research and innovation centre, known as W21C, forms section three of this volume. The paper, *Academic Literature Review of Preferential Access to Health Care in Canada*, is a review of the academic literature on preferential access to health care as it pertains to the Canadian system. Referencing peer-reviewed journal articles that are applicable to the Canadian context, this review helps define what preferential access or "queue-jumping" means in the Canadian health care system from an academic point of view.

The final section contains the *Renal Dialysis Rimbey Support Group Report*, produced by Dr. John Church. The Commissioner had invited the Group to make a formal written submission. This report was entered as exhibit 152 during hearings on February 27, 2013. The report focuses on the financial, safety and health costs associated with the travel necessary for residents of one rural community to receive dialysis services.

The opinions expressed in each paper are those of the author(s) alone and do not necessarily reflect the position of the inquiry. The documents contained in this volume are reproduced in the form in which they were presented to the inquiry and have not been substantially edited by inquiry staff

The Legislative Framework Governing Access to Health Services that are "Insured Health Services" under the *Canada Health Act* and "Insured Services" under the Legislation of Alberta

Professor William Lahey

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1. Expert Reports

(a) The Legislative Framework Governing Access to Health Services that are "Insured Health Services" under the *Canada Health Act* and "Insured Services" under the Legislation of Alberta

Professor William Lahey

EXECUTIVE SUMMARY

In every province and territory, Canadians have a statutory entitlement to receive medical (and some dental) services and hospital services that are determined to be medically necessary at public expense without charges at the point-of-service.

This entitlement is designed to ensure that Canadians have access to these services on the basis of relative need rather than on the basis of relative wealth. It therefore ensures a significant measure of equality of access, particularly among the residents of each province or territory, to most medical and hospital services. In a nutshell, this system is what is called Medicare.

The existence of Medicare as a quasi-national program depends upon the *Canada Health Act*. The function of the *Canada Health Act* is to establish the criteria and conditions of eligibility that each province or territory must satisfy to receive their full share of the annual cash contributions to health-care spending, called the Canada Health Transfer, that the federal government decides to make to the provinces and territories. These eligibility criteria and conditions apply to the design and functioning of the health-care insurance plan that the Act says each province and territory must have.

Pursuant to the *Canada Health Act*, a provincial health-care insurance plan must meet the five "program criteria" of:

1) public administration;
2) comprehensiveness;
3) universality;
4) portability; and

5) accessibility ("the Five Criteria").

In addition, in respect to the health services that the plan insures, extra-billing and user charges must not be permitted under the plan.

The overall effect of the *Canada Health Act* is that each province or territory that wants its full share of the Canada Health Transfer has to establish a health-care insurance plan that is administered by a public authority accountable to the provincial or territorial government and that pays 100% (more or less) of the cost of a comprehensive range of medical and hospital services whenever they are provided, with limited exceptions, to any resident of the province or territory.

The clear exceptions in the legislation occur where medically necessary services are provided to injured workers entitled to the service under workers' compensation legislation, to members of the Canadian Forces, to federal inmates, or to provincial or territorial residents who have not met the residency requirement of three months or less set by the province or territory. The result of the exceptions is that these individuals either pay for medical services, or medical services are provided to them through a program other than the provincial health-care insurance plan.

The more uncertain exceptions relate to services that may or may not be "medically necessary" and therefore might arguably fall outside of the *Canada Health Act*. This uncertainty has applied to certain diagnostic services when provided outside of a hospital.

Alberta has a legislative framework that creates the health-care insurance plan required by the *Canada Health Act*. Alberta has created two separate health-care insurance plans.

The first, the Alberta Health Care Insurance Plan, covers medical services. This plan is established and operated under the *Alberta Health Care Insurance Act* and its regulations. The second plan, the Hospitalization Benefits Plan, covers hospital services. The Hospitalization Benefits Plan is established and operated under Part 3 of Alberta's *Hospitals Act*.

Both of these Plans are consistent with each other in entitling Albertans to access without any charge at the point-of-service to what is defined in Alberta as medical and hospital services that are medically

necessary, subject to the exceptions provided for in the *Canada Health Act*.

Like all other provinces, except one, Alberta goes further than is required by the *Canada Health Act* in seeking to ensure that these services are for the most part only available through the Alberta Health Care Insurance Plan and the Hospitalization Benefits Plan.

The *Alberta Health Care Insurance Act* accomplishes this goal by requiring physicians who wish to provide any of these services for private payment to opt out of the Alberta Health Care Insurance Plan and to forego all reimbursement under that Plan. In addition, Alberta, like a number of other provinces, prohibits the selling or purchase of private insurance for services available under the Alberta Health Care Insurance Plan and the Hospitalization Benefits Plan.

Alberta's "Medicare legislation" includes the *Health Care Protection Act.* This Act creates a regulatory framework for the operation of private surgical clinics that stresses consistency with the *Canada Health Act*. It authorizes the establishment, with Ministerial approval, of designated surgical facilities that can, like public hospitals, provide insured and uninsured surgical services as well as "enhanced medical goods and services".

When the designated surgical clinics provide insured surgical services, they do so under a minister-approved agreement with Alberta Health Services (or a predecessor regional health board) under which the cost of the service is paid for by the public system. Designated clinics also provide uninsured surgical services and enhanced medical goods and services for payment by the patient or a third-party payer other than Alberta's two health-care insurance plans.

The *Health Care Protection Act* also contains a number of distinct but overlapping provisions that are intended to prevent preferential access to services that should be delivered as insured services. In particular, section 3 of the *Health Care Protection Act* contains an express prohibition on queue jumping.

The following summary is intended to provide a general overview of the key elements of the primary pieces of legislation which govern Medicare in Alberta:

The *Canada Health Act*:

- Seeks to ensure that Canadians have universal and reasonable access on uniform terms and conditions to a comprehensive range of physician and hospital services on the basis of need and without regard to individual ability to pay;
- Authorizes the federal government to make health transfers to provinces and territories that are determined by the federal government to have a health care insurance plan, or plans, that comply with the *Canada Health Act*;
- Establishes the criteria and conditions which each province and territory must satisfy to receive its full annual share of the Canada Health Transfer;
- Requires each province and territory to establish and maintain a health care insurance plan for medically necessary hospital services and medically required physician services, including some dental-surgical services, which meets five program criteria: public administration; comprehensiveness; universality; portability; and accessibility;
- Requires each province and territory to prevent extra-billing and user charges under its health care insurance plan (or plans);
- Authorizes the federal government to withhold or reduce cash transfers otherwise payable in the event of failure by a province or territory to comply with one or more of the program criteria and requires the federal government, where extra-billing or user charges are permitted, to deduct the total amount charged to patients from transfers otherwise payable;
- Leaves the critical phrases “medically necessary” and “medically required” undefined, giving each province and territory significant latitude to determine the services that it will fund as medically necessary or required;
- Excludes hospital and physician services provided under workers’ compensation legislation or to members of the Canadian Forces, federal inmates and non-residents of a province; and

- Deals with how hospital/physician services are to be funded, not with how services are to be delivered, leaving service delivery choices to provinces and territories.

The *Alberta Health Care Insurance Act*:

- Establishes entitlement for all residents of Alberta (as defined) to basic health services, which are defined to include the services that Alberta insures as medically necessary physician and dental-surgical services, called "insured services";
- In accordance with the *Canada Health Act*, establishes the Alberta Health Care Insurance Plan, which is Alberta's health care insurance plan for the services that Alberta insures as medically required physician services and dental-surgical services;
- Excludes services provided under workers' compensation legislation or to members of the Canadian Forces, federal inmates and non-residents of Alberta;
- Expressly prohibits extra-billing and the charging of other fees in respect of insured services by physicians and dentists who are "opted-in" to the Alberta Health Care Insurance Plan; and
- Deems physicians and dentists to be opted-in to the Alberta Health Care Insurance Plan and discourages "opting out" by: requiring physicians to publicly do so for all purposes; prohibiting payments to physicians and reimbursement of patients for services received from opted-out providers in most circumstances; and prohibiting private insurance for services covered by the Plan.

The Alberta *Hospitals Act*:

- Establishes entitlement for all residents of Alberta (as defined) to medically necessary hospital services, called "insured services";
- In accordance with the *Canada Health Act*, establishes the Hospitalization Benefits Plan, which is Alberta's health care insurance plan for medically necessary hospital services;

- Excludes hospital services provided under workers' compensation legislation or to members of the Canadian Forces, federal inmates and non-residents of Alberta;
- In respect of insured services, prohibits the charging of user-charges or fees; and
- Prohibits private insurance for services covered by the Hospitalization Benefits Plan.

The *Health Care Protection Act*:

- Prohibits the provision of surgical services except in a public hospital or in an approved surgical facility;
- Prohibits the provision of major surgical services except in a public hospital;
- Establishes a legislative framework for purchase and provision of insured and uninsured surgical services;
- Differentiates between insured services (for which patients cannot be charged) and "enhanced medical goods or services" (which can be purchased by patients either with or independently of insured services);
- Subject to the limitation that major surgical services must be provided in a public hospital and the other requirements of the Act:
 - permits designated surgical facilities to provide insured surgical services (under agreements with Alberta Health Services that are approved by the Minister of Health), uninsured surgical services and enhanced medical goods and services;
 - permits accredited surgical facilities that are not designated to provide uninsured surgical services that require less than 12 hours of medically supervised post-operative care and enhanced medical goods and services; and
- Contains various provisions, including a prohibition of queue jumping, that are intended to ensure that access to insured surgical services is in accordance with the *Canada Health Act*

and the underlying objective of the *Canada Health Act*, which is access based on need without regard to ability to pay.

1. Introduction

a) Overview of Canadian Medicare

Across Canada, Canadians are generally entitled under the laws of their province or territory of residence to receive three categories of health service without being charged for the service: (1) medically required services provided by a physician; (2) medically necessary services provided by a hospital; and (3) surgical-dental services that are medically or dentally required if performed in a hospital where the service is one that must be provided in a hospital.[1]

The health services that fall into these three categories are generally called "insured health services".[2]

Legislation in every province and territory provides for remuneration of the physician (or dental surgeon) or the funding of the hospital that delivers these services by a publicly administered health insurance plan that is funded either by (a) general government tax revenue or (b) by a combination of general tax revenue and a dedicated health premium paid separately from taxes by provincial residents.[3]

The starting point in this Canada-wide legislative consistency is the *Canada Health Act.*[4] This federal legislation entitles every province and territory that maintains the legislative framework described above to its share of the cash transfers that the federal government annually makes to the provinces and territories in respect of the expense the provinces and territories incur in funding health care, including by paying 100% of the cost of what the *Canada Health Act* defines as "insured health services".

The annual transfer provides a significant financial incentive to the provinces to comply with the *Canada Health Act*, notwithstanding that

[1] *Canada Health Act*, RSC 1985, c C-6 [CHA] at s 2. See Appendix A for a full list of relevant sections of the *Canada Health Act* discussed in this report.
[2] *Ibid.*
[3] See *CHA Report, infra* note 15 at Chapter 3.
[4] *CHA, supra* note 1.

the Act is not written, and could not be written for constitutional reasons, to be legally enforceable against the provinces.

It is estimated that in 2012, provincial and territorial government health expenditures will reach $135 billion. Spending on health care is one of the largest budget items for all provinces. As a percentage of provincial expenditure it ranges from 30.1% in Quebec to 47.9% in Nova Scotia. On a per capita basis, it ranges from $4,606 annually per person in Alberta (second highest) to $3,513 annually per person in Quebec (the lowest).[5]

In a nutshell, this is what Canadians know as Medicare, a quasi-national program that is available to citizens because of the legislation of their province or territory of residence, but that ultimately also rests on the federal *Canada Health Act*. It seeks to ensure general access to necessary physician and hospital services (as well as some dental services) by eliminating the role that each individual's wealth would otherwise play in determining their ability to access these services.

Therefore, to the significant degree that relative access to these services would otherwise depend on each person's financial capacity, Medicare seeks to ensure equality of access to the health services it encompasses.

At the same time, Medicare protects individuals and families from the financial stress that many would otherwise face if they were required to pay with personal resources for some or all of the expensive services that Medicare covers.

b) Variance of Scope of Medicare Among the Provinces

Even though Medicare has a clear national dimension, the scope of Medicare varies among the provinces and territories. Provinces and territories differ as to how they apply the key concepts of "medical necessity" (in relation to hospital services) and "medically required" (in relation to physician services). This means that Medicare encompasses more (or fewer) health services in some provinces and territories than in others. Physician and hospital services that are excluded from Medicare are generally services that Canadians pay for out-of-pocket or with private health insurance, typically associated with employment.

[5] See Canadian Institute for Health Information, "National Health Expenditure Trends, 1975 to 2012" (2012), online: <www.ciha.ca>.

In addition, for the physician and hospital services that are treated as an insured service within Medicare in all or most provinces and territories, the service may for practical reasons be more readily available in some than in others. For example, one province may be able for fiscal capacity or other reasons to make certain services more available to its residents than another province can. For similar kinds of practical reasons, there is also variation in access to insured services within provinces, including between people who live in rural and urban communities.

While these variations in what Medicare includes and in how it operates do exist, it is important to keep them in the perspective of the bigger picture, which is that Medicare makes most of the services provided by doctors and hospitals available to most Canadians without personal expense.

There is more extensive variation among provinces and territories on their funding of health services not included in Medicare. These services include home care, long-term care, most of dental care, various kinds of therapy provided by care providers other than doctors, and prescription drugs, except when they are provided in hospital.

Provinces and territories fund these services to varying degrees or not at all, depending on their health policy priorities and fiscal capacity. The funding that is provided is often subject to cost-sharing (through deductibles, co-pays or user fees) that is inapplicable to services funded within Medicare. In many cases, funding or the amount of funding that is provided for these services depends on whether the patient or user of the service is a child, senior citizen or has a low income. The *Canada Health Act has* no applicability to the decisions which provinces make about public funding for the services not included in Medicare.[6]

[6] Some of these services are what the *Canada Health Act* calls "extended health care services", which are defined to mean nursing home intermediate care service, adult residential care service, home care service and ambulatory health care service: *CHA*, *supra* note 1, s 2. The requirement that the provinces and territories provide information to the federal Minister of Health and that they give recognition to the Canada Health Transfer in public documents and advertising or promotional material applies to extended health care services, but the Five Criteria and the requirement to prevent extra-billing and user charges do not.

2. The Legislative Framework of Medicare

a) The Canada Health Act

i) What Does the Canada Health Act *Do?*

The subject matter of the *Canada Health Act*[7] is the federal government's annual distribution of the cash portion of the Canada Health Transfer (the "CHT") to the provinces and territories.[8]

The CHT is the federal contribution to provincial and territorial spending on health care. It consists of tax points (i.e. taxing room) that the federal government permanently transferred to the provinces in the 1970s and a cash portion that is distributed among the provinces and territories on an annual basis according to a formula established by the federal government, with or without discussions with the provinces and territories. The total amount of funding distributed each year is also determined by the federal government, again, with or without discussions with the provinces and territories. These decisions about the size of the CHT and the formula for its distribution are not made under the *Canada Health Act* but through federal budgetary legislation.

What the *Canada Health Act* does do is establish the criteria and conditions that each province must satisfy in order to receive their full share of the CHT available under federal budgetary legislation.[9] At a high level, the Act specifies the circumstances in which the federal government must pay a province or a territory its full share of the CHT; the circumstances in which it has the discretion to reduce or withhold the cash portion of the CHT otherwise payable to a province or territory; and the circumstances in which it must apply deductions to the share of the cash portion of the CHT otherwise payable to a province or territory.[10]

[7] *CHA, supra* note 1.
[8] Although the *Canada Health Act* only refers to the provinces, it is administered by the federal government as also applicable to the territories.
[9] *Ibid*, ss 7-13.
[10] *Ibid.*

ii) Provincial & Territorial Entitlement to the CHT & Authority to Reduce the Transfer

Under the *Canada Health Act*, a province or territory is entitled to its full share of the CHT when it has:

a) established and maintained a "health care insurance plan" that satisfies the Five Criteria of public administration, comprehensiveness, universality, portability, and accessibility;[11]

b) provided the Minister of Health with information as prescribed by Regulation on its compliance with the Act, including the Five Criteria, and given recognition to the CHT in public documents and advertising and promotional material;[12] and

c) not permitted extra-billing by physicians (or by dentists providing covered surgical-dental services) or user charges (generally called user fees in the literature) under its health-care insurance plan.[13]

The *Canada Health Act* gives the federal government discretionary authority to reduce or to withhold the CHT payment that otherwise would be payable to a province or territory where it determines that the health-care insurance plan of the province or territory does not meet one or more of the Five Criteria. The federal government is also entitled to exercise this discretion upon failure of the province or territory either to provide the Minister of Health with the information prescribed by Regulation or to give recognition to the CHT in public documents or advertising or promotional material.[14]

This authority to reduce or withhold the CHT is conferred on the Governor in Council and can only be exercised after the Minister of Health has consulted with the provinces or territories in question.[15]

[11] *Ibid*, s 7.
[12] *Ibid*, s 13.
[13] *Ibid*, ss 18 & 19.
[14] *Ibid*, ss 14-17.
[15] *Ibid*. Since April of 2002, interpretation and administration of the *Canada Health Act* is also subject to a Dispute Avoidance and Resolution Process which was agreed to between the federal government and all provinces and territories except Quebec, as set out in a letter from then-federal Minister of Health Anne McLellan to her provincial and territorial counterparts. The letter is an annex to the annual report that Health Canada issues on the *Canada Health Act*: see Health Canada, *Canada Health Act Annual Report 2010-2011*, (Ottawa, Health

The authority has never been used to reduce or withhold the transfers otherwise payable to a province or territory.[16]

iii) Extra Billing, User Fees & Impact on Canada Health Transfer

Should a province or territory permit patients to be extra-billed (by physicians or by dentists providing covered dental-surgical services) or to be charged user charges for insured services, the *Canada Health Act* requires the total of the amounts charged to patients to be deducted from the CHT contribution otherwise payable.[17] Deductions under these provisions have been applied to the federal contribution paid to various provinces on a number of occasions.[18]

Extra-billing means charging a fee in addition to the compensation for providing a service that the physician recovers from the health care insurance plan.[19] User charges are any other fee charged to a patient that is not recoverable from the applicable provincial or territorial health care insurance plan.[20]

It has been stated that the prohibition of extra-billing and user fees that the *Canada Health Act* indirectly imposes on physicians and hospitals constitutes the truly unique element of Canada's approach to the public funding of essential health services.[21] Other countries publicly fund general access to the physician and hospital services that are encompassed by the *Canada Health Act*. But none go as far as Canada does in trying to make public funding the sole and exclusive source of funding for these services by "banning" extra-billing and user fees in the provision of these services.

Canada, 2012) [*CHA Report*].
[16] *Ibid* at 6.
[17] *CHA*, *supra* note 1, ss 18, 19 & 20.
[18] *CHA*, Report, *supra* note 15 at 10-2.
[19] *CHA*, *supra* note 1, s 2.
[20] *Ibid.*
[21] Colleen M Flood, "The Anatomy of Medicare" in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds, *Canadian Health Law and Policy*, 2d ed (Markham, ON: Butterworth's, 2002) at 27.

iv) What Provinces and Territories Must Do to Satisfy the Canada Health Act

Leaving aside the annual reporting and recognition requirements, it follows from the above summary of the *Canada Health Act* that the eligibility of a province or territory for its full share of the cash portion of the CHT comes down to two questions:

a) does it maintain a "health care insurance plan" that meets the Five Criteria?, and

b) does it prevent extra-billing and the charging of user fees in respect of the services that are insured under that plan?

Taken together, the Five Criteria require each province and territory to establish a publicly managed single-payer system of health care funding under which the provincial or territorial government – or an agency that is accountable to it – pays the full cost of universal access to a comprehensive range of medical and hospital services.

The criteria that are most directly related to the question of access to services and the objective of equality of access are public administration, comprehensiveness, universality, and accessibility. Portability is also important to access and increasingly so in a highly mobile society, but primarily as an adjunct to the access that is guaranteed by the other four criteria.

The following discussion will therefore focus primarily on public administration, comprehensiveness, universality, and accessibility, while touching more briefly on portability.

A) Criterion #1: Public Administration

The criterion of public administration is fundamental to the single-payer model of health care insurance that is envisaged by the *Canada Health Act*. It requires the health care insurance plan of provinces and territories to be administered and operated on a non-profit basis by a public authority that is appointed or designated by, and is responsible to, the government of the province or territory.[22] In

[22] *CHA*, *supra* note 1, s 8.

most jurisdictions, including Alberta, the designated authority is the minister of health, i.e., Alberta's Minister of Health.

The requirement for public administration ensures political accountability for administration and operation of health care insurance plans. More to the point, it requires the provinces and territories to be accountable for establishing and maintaining plans that directly fund medical and hospital services instead of plans that subsidize the purchase of private insurance, which could be insurance on differential terms reflecting factors such as age, gender, occupation and health status.[23] In this respect, the public administration criterion works with the universality and the accessibility criteria, both of which require insurance to be provided on "uniform terms and conditions".[24]

In conjunction with the requirement of universal coverage under the universality criteria, the public administration criterion ensures that each health care insurance plan functions as a centralized payer for all of the services that the plan is required to include under the criteria of comprehensiveness. This avoids the cost of multiple administrative structures and was intended to contribute to cost control by giving governments, as single-payers, greater bargaining power with providers. It also ensures that everyone in a province or territory, with certain limited exceptions, depends on the same third-party funder to pay for most of the physician and hospital services they require.

There is a limit to how far the *Canada Health Act* goes in requiring the provinces and territories to insure their residents for medical and hospital services through a single publicly administered plan. The *Canada Health Act* does not require prohibition of private insurance that covers services included in the public plan. Six provinces, including Alberta,[25] have nevertheless prohibited such insurance, presumably to ensure that public health care insurance plans

[23] Odette Madore, *Current Issue Review* – The *Canada Health Act:* Overview and Options (Ottawa: Library of Parliament – Parliamentary Information and Research Service, 2005) at 6 [Madore].
[24] *CHA, supra* note 1, ss 10 & 12.
[25] *Alberta Health Care Insurance Act*, RSA 2000, c A-20, s 26(2) *[A-HCIA];* and *Hospitals Act,* RSA 2000, c H-12, s 44 [HA].

are truly the single and exclusive payer for the services they encompass.[26]

B) Criterion #2: Comprehensiveness

Comprehensiveness requires the health care insurance plan of a province or territory to insure "all insured health services rendered by hospitals, medical practitioners or dentists".[27]

The *Canada Health Act* defines "insured health services" as "hospital services, physician services and surgical-dental services provided to insured persons".[28] Each of these terms is in turn defined.

For services provided by hospitals and physicians, the net effect of the definitions can be summarized as follows: comprehensiveness requires a health-care insurance plan to insure all the services provided by hospitals that are "medically necessary" and all services provided by physicians that are "medically required" when they are provided (with some exceptions) to persons lawfully in Canada who are residents of the province or territory.

In summary then, the meaning of comprehensiveness depends on the meaning of "insured health services" and of "insured persons". Each of these key phrases will be discussed separately, keeping in mind that comprehensiveness depends on their combined effect.

I. Definition of "Insured Health Services"

Given that the services that hospitals and physicians provide are generally those that are medically necessary or required, the general intent of the *Canada Health Act* is clear: it is to require health care

[26] Colleen M Flood & Tom Archibald, "The illegality of private health care in Canada" (2001) 164:4 CMAJ 825 at 825, 828-829 [Flood & Archibald]. The Quebec version of this prohibition was found to be contrary to the *Quebec Charter of Human Rights and Freedoms* by the Supreme Court of Canada where the public system was found by the Court to be failing to provide the level of access to services that was required by the *Charter's* right to personal inviolability (equivalent to the right to security of the person under the *Canadian Charter of Rights and Freedoms): Chaoulli v Quebec (Attorney General),* [2005] 1 SCR 791. Quebec has subsequently reinstituted the prohibition while excluding certain insured services from its scope and stipulating that private insurance, where it is permitted, must cover not only the cost of the insured service but also of preoperative, postoperative, rehabilitative and home care support services; *Health Insurance Act,* RSQ, c A-29, s 15.

[27] *CHA, supra* note 1, s 9.

[28] *Ibid*, s 2.

insurance plans to fund most of the services provided by hospitals and physicians as "insured health services". The criterion is, after all, the criterion of *comprehensiveness*.

It is critical to note however that the *Canada Health Act* does not define the operative concepts of "medically necessary" or "medically required".

This omission provides latitude for the health care insurance plan(s) of each province and territory to determine the boundary between hospital and physician services that are deemed to be or not to be medically necessary or required.

This latitude can result in delays in funding for new services or new ways of providing services as medical technology evolves. It can be used to refuse to fund services that have been characterized as "emergent services".[29] It has been used to "de-list" procedures which were at one time funded as medically necessary.[30] It has been used to refuse to fund services that are deemed to be purely aesthetic or associated with lifestyle choices or a desire for an enhancement of some area of physical functioning, such as fertility.[31] It can also be used to refuse to fund treatment options that are regarded as in excess of what is truly needed by the patient to address their condition. For example, where a patient needs a hip replacement it will be clear that an artificial hip is medically necessary, but it may not be clear that he or she needs the most expensive artificial hip on the market.

a) Workers' Compensation Benefits and "Insured Health Services"

The definition of "insured health services" excludes health services that a person is entitled to receive under federal or provincial

[29] *Auton (Guardian ad litem of) v British Columbia (Attorney General),* [2004] 3 SCR 657.

[30] A dated but indicative table of the kinds of services that have been "de-insured", mostly in the 1990s, can be found in Odette Madore, *supra* note 23 at 15. The services that have been de-listed in one or more provinces include minor procedures, such as wart or ear wax removal, and more significant procedures such as treatments for infertility. See M Giacomi, J Hurley & G Stoddart, "The many meanings of deinsuring a health service: the case of in vitro fertilization in Ontario" (2000) 50 Social Science & Medicine 1485-1500.

[31] *Cameron v Nova Scotia Attorney General* (1999), 177 DLR 611 (NSCA).

workers' compensation legislation.[32] This is a carry-over from the predecessor legislation to the *Canada Health Act*.[33] The rationale for this exclusion was that people who needed medical care to address workplace injuries or illness would not need public health care insurance because they already would have access to the care they needed through the medical benefits they would be entitled to receive under workers' compensation legislation.

The exclusion of workers' compensation services means that compliance with the *Canada Health Act* is not jeopardized if injured workers receive access to medical or hospital services that would, but for the exclusion, fall under the definition of insured health services on terms and conditions that are different from those that determine the access to the same services under the health care insurance plan of a province or territory. This has become controversial because of the concern of some that workers' compensation boards are purchasing faster access for injured workers to services such as orthopedic surgery that other Canadians receive through Medicare by waiting their turn.

In 2002, Commissioner Romanow characterized the exclusion of services provided to injured workers as one of the "grey areas around the issue of private for-profit delivery" and expressed agreement with those who thought this should "be redressed in a modernized *Canada Health Act*".[34]

b) Diagnostic Services and "Insured Health Services"

Medicare was intended to include diagnostic procedures: the hospital services portion of Medicare was originally established under the *Hospital Insurance and Diagnostic Services Act*.[35]

[32] *CHA*, *supra* note 1, s 2.

[33] *Hospital Insurance and Diagnostic Services Act*, SC 1957, c 28, s 2(g) [*HIDSA*]; and the *Medical Care Act*, SC, 1966, s 2(e).

[34] Commission on the Future of Health Care in Canada, Roy J Romanow, Commissioner, *Building on Values: The Future of Health Care in Canada* (Ottawa: Commission on the Future of Health Care in Canada, 2002) at 7-8 & 64-65 [*Romanow Report*].

[35] *HIDSA*, *supra* note 33.

Under the *Canada Health Act*, the definition of insured health services includes "hospital services" and diagnostic procedures are among the services listed under the definition of "hospital services".[36] But like all other services on that list, diagnostic procedures are considered a hospital service if they are provided to a hospital patient.

The definition of insured health services also includes physician services, which are defined simply to include "any medically required services rendered by medical practitioners".

There is no express mention of diagnostic services, or of other kinds of hospital services, in the definition of insured health service.

After the adoption of the *Canada Health Act* in 1984, developments in medical technology allowed diagnostic procedures as well as a range of surgical procedures to be delivered outside of hospitals, specifically in private clinics. The absence of a specific reference to diagnostic procedures in the definition of insured health services resulted in divergent views as to whether diagnostic procedures provided in a private clinic were outside of the *Canada Health Act*. A similar divergence of views can exist with respect to certain surgical services, but there has been a particular focus on the question of how the *Canada Health Act* applies to diagnostic procedures.

Health Canada has taken to view that those diagnostic procedures that are delivered as insured services must be treated as insured services for all purposes, whether they are delivered in a hospital or a clinic. This was clarified in 1995 when then-federal Health Minister Diane Marleau wrote to provincial and territorial ministers of health to advise that she would make deductions from the health transfers of jurisdictions that allowed private clinics that were funded to provide insured services to charge "facility fees" (i.e. "user charges") to the patients who received those services ("the Marleau Letter").[37] At the time of the Marleau Letter diagnostic services paid for by the health care insurance plans of several provinces were among the services for which private clinics were charging facility fees.

[36] *CHA*, *supra* note 1, s 2.
[37] *CHA Report*, *supra* note 15 at Annex B, 171-173.

Health Canada subsequently proceeded to make deductions from federal transfers until it was satisfied that the provinces in question had acted to eliminate the offending facility fees. The Marleau Letter continues to be cited by Health Canada as a policy statement that reflects the federal position on the *Canada Health Act*.[38]

The Marleau Letter did not deal with diagnostic procedures purchased by or on behalf of patients outside of Medicare. This can happen in two situations. In the first situation, the procedure is not thought to be strictly necessary from a medical point of view but the patient wants and is willing to pay for it nevertheless. This is a scenario that is more likely with some kinds of diagnostic procedures than it will be with other kinds of medical procedures. In the second situation, the procedure is medically necessary and therefore available through the public system, but the patient is prepared and able to pay for it personally, usually to get it faster than he or she can get it in the public system. In that situation, the argument for regarding the service as being outside of the *Canada Health Act* is that the patient is paying to have the service more quickly than the public system, given factors such as prevailing waiting lists and clinical prioritization decisions, deems it to be medically necessary.

Where the service is provided on the basis that it is being provided before it has become medically necessary, a question arises as to whether access to a necessary diagnostic procedure is being determined by differences in the personal ability to pay for it. In both situations, there is a concern that privately funded access to a diagnostic procedure can result in preferential access in the public system to the treatments that the diagnostic procedure may reveal are indicated.

These concerns were raised by Health Canada with various provinces between 2000 and 2005.[39] In 2002, they led Commissioner Romanow to make two recommendations: amendment of the *Canada Health Act* to explicitly include diagnostic services in the definition of insured health services; and a significant investment in the capacity

[38] *Ibid* at 7.
[39] Madore, *supra* note 23 at 8-11.

of the public system to provide timely diagnostic procedures.[40] The recommended change to the Act has not been made.

II. Definition of "Insured Persons"

Comprehensiveness requires a health-care insurance plan to insure medically necessary (or required) services when they are provided to a person who is an "insured person".[41]

a) Residents of a Province

Subject to important exceptions discussed below, the *Canada Health Act* defines an insured person as "a resident of the province".[42]

The *Canada Health Act* goes on to define "resident" as a person "lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province".[43] The limitation of the definition to persons "lawfully entitled to be or to remain in Canada" means, for example, that provinces and territories can insure those waiting for a determination of their refugee claim, but are not obliged to do so.

b) Excluded Persons: Members of Canadian Forces, Federal Inmates, Non-Residents

The definition of "insured person" expressly excludes members of the Canadian Forces, federal inmates and persons who have not completed the waiting period of three months or less that the province or territory may require before allowing a person who moves to the province or territory to become an insured person.[44]

Until recently, members of the RCMP were also excluded, but this exclusion was recently removed from the Act.[45] The result presumably is that members of the RCMP will now be insured persons under the health-care insurance plan of the province or territory in which they are a resident.

[40] *Romanow Report, supra* note 34 at 6-9, 59-60, 64-65 & 71-72.
[41] *CHA, supra* note 1, ss 9 & 2.
[42] *Ibid*, s 2.
[43] *Ibid*.
[44] *Ibid*.
[45] SC 2012, c 19, s 377.

The rationale for the exclusion of members of the Canadian Forces and federal inmates (and until recently, RCMP members) is that they are provided health care by or at the expense of the federal government. Their exclusion from Medicare is therefore based on a similar rationale as the exclusion of services provided through workers' compensation benefits.

The situation of people moving from one province to another will be similar. These people will generally be insured persons under the health care insurance plan of their province or territory of origin during the period of three months or less that their new province or territory requires them to wait before enrolling them in its health-care insurance plan.

Here, the comprehensiveness criterion works with the portability criterion.[46] In general terms, the latter says that provincial and territorial health-care insurance plans must not impose minimum residency requirements in excess of three months. It also says that plans must provide for the payment of the cost of insured health services provided to their residents by another province or territory when their residents are visitors to the other province or territory or have moved to another province or territory and receive insured health services during the minimum residency requirement of that province or territory.[47]

The exclusion of certain categories of persons from the definition of insured person means that the level and terms of access to medical and hospital services that is provided to these persons is irrelevant to provincial or territorial compliance with the *Canada Health Act*.

It also means that the eligibility of a province or territory for funding under the *Canada Health Act* is not jeopardized if physicians or hospitals directly charge persons in these limited categories for medically necessary hospital or physician services. Practically speaking, these charges will be paid by the federal government in the case of members of the Canadian Forces and federal inmates. They may or may not be paid by a third-party payer in the case of new arrivals to Canada or in the case of visitors if the visitor is from outside

[46] *CHA, supra* note 1, s 11.
[47] *Ibid*, s 11(2).

Canada or is from within Canada seeking elective insured health services that they could have received in their home province.[48]

c) First Nation and Inuit Canadians are not Excluded

Finally, because the federal government is heavily involved in funding or in funding and providing certain health-care services to First Nation and Inuit Canadians, it should be noted that these Canadians are not excluded from the definition of insured person under the *Canada Health Act*.[49]

The contrary impression may be created by the range of health-care services that the federal government funds or funds and provides for these Canadians, which includes primary care and emergency services in remote and isolated communities; community-based public health and health promotion programs on First Nation reserves and in Inuit communities; and a non-insured health benefits program that covers spending on dental, drug and vision care. However, the reality is that First Nation and Inuit Canadians are residents of their provinces or territories who are not excluded from the definition of insured person found in the *Canada Health Act*. As such, they are persons who must be insured by the health care insurance plans of their provinces or territories of residence.

C) Criterion #3: Universality

To satisfy the universality criterion, the health care insurance plan of a province or territory "must entitle one hundred per cent of the insured persons of the province (or territory) to the insured health services provided for by the plan on uniform terms and conditions".[50] "Insured person" has the same meaning under universality as under comprehensiveness: every resident of the

[48] Subsection 11(2) of the *Canada Health Act* says that the portability criterion is not contravened where a province or territory makes payment for the cost of an elective service received in another province or territorial conditional on its prior consent to the provision of the service in the other province or territory where the service is available on substantially similar terms in the province or territory.
[49] *Ibid*, s 2.
[50] *Ibid*, s 10.

province or territory who does not fall into one of the limited categories of exclusion.[51]

The universality criterion does two things: it says that all of the people within the definition of "insured person" must be insured and it says that they must all be insured "on uniform terms and conditions".[52] The requirement of coverage on "uniform terms and conditions" means that different premiums or different eligibility requirements cannot be imposed to reflect differences in factors such as age, gender, occupation, or health status.

The rationale of the universality criterion is to ensure general equality of access, to the extent that it depends on ability to pay, to the services that a health-care plan is required to fund in order to satisfy the comprehensiveness criteria. The standard of equal access implied is, however, a provincial or territorial one and not a national one: the requirement is entitlement on uniform terms and conditions among "one hundred percent of the insured persons *of the province (or territory)*".[53]

The universality criterion, like all the others, applies to the health-care insurance plan of a province and not to its health-care system. Accordingly, what it requires is entitlement on uniform terms and conditions insofar as this can be accomplished by a single-payer system of health-care insurance that is operated by or on behalf of the government of each province or territory.

D) Criterion #4: Accessibility

The accessibility criterion has a number of distinct elements relating to the processes and mechanisms that health care insurance plans must follow to compensate physicians and fund hospitals.

For example, it requires provinces and territories to pay "reasonable compensation" to physicians and dentists and says that this requirement is deemed to be complied with where the province (or territory) and its physicians and dentists (through their representative organizations) have agreed to negotiate compensation for provision of insured

[51] *Ibid,* s 2.
[52] *Ibid,* s 10.
[53] *Ibid.*

services and to settle compensation disputes through conciliation or binding arbitration.[54]

The more general requirement under the accessibility criterion is that the health care insurance plan of a province or territory "must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges or otherwise, reasonable access to those services by insured persons".[55]

Accessibility thus comes into play where universality leaves off: it repeats the requirement for uniform terms and conditions of access but adds that the access must also be "reasonable".

What reasonableness means in this context is not defined. Given, however, that medical necessity is the basis on which a service becomes a service that must be insured, it would seem that the reasonableness of access to those services would also depend on what is medically necessary. Guidance might also be taken from section 3 of the *Canada Health Act*, which states that "the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada".[56]

It should also be recognized that the accessibility criterion is not the only part of the *Canada Health Act* that addresses accessibility. The Act as a whole is about accessibility to medically necessary (or required) medical and hospital services. In many ways, the most rigorous "accessibility" feature of the *Canada Health Act* is not the criterion itself but the requirement under section 18 that provinces and territories not allow extra-billing and under section 19 that they not allow user charges.

The accessibility criterion is written in general terms to potentially reference whatever impedes or precludes reasonable access to insured services, "either directly or indirectly whether by charges or otherwise".[57] But, like the Five Criteria in general, accessibility is a criterion that must be satisfied by the health care insurance plan of

[54] *Ibid*, s 12(2).
[55] *Ibid*, s 12(1)(a).
[56] *Ibid*, s 3.
[57] *Ibid*, s 12(1)(a).

a province or territory, not by health care delivery within the province or territory.

v) Public Financing, Public and Private Delivery

The *Canada Health Act* deals with the question of how the provision of hospital and physician (and some dental) services is funded rather than with the question of how these services are delivered. Therefore, it can be said that compliance with the Act requires public financing of the services it encompasses but not public delivery of those services.[58]

From time to time, the administration of the *Canada Health Act* has suggested that the federal government regards the accessibility criteria (and the comprehensiveness criteria) as potentially extending into general health care system design and administration, particularly in relation to the role of private clinics. But the more general federal pattern has been to focus on the design and functioning of provincial health care insurance plans. This focus aligns with the interpretive approach outlined in a letter sent to provincial and territorial health ministers in 1985 by then-federal Health Minister Jake Epp, which is still cited as applicable to the interpretation of the *Canada Health Act* by Health Canada.[59]

3. Alberta Legislation

a) The Alberta Health Care Insurance Act *and the* Hospitals Act

The Alberta version of the health care insurance plan that is required by the *Canada Health Act* is partly established under the *Alberta Health Care Insurance Act*[60] (the "*A-HCIA*") and partly established under the Alberta *Hospitals Act*.[61]

[58] William Lahey, "Medicare and the Law: Contours of an Evolving Relationship" in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds, *Canadian Health Law and Policy*, 4th ed (Markham: Lexis Nexis, 2011).
[59] CHA Report, *supra* note 15 at Annex B, 165-170.
[60] *A-HCIA*, *supra* note 25. See Appendix A for a full list of relevant sections of the *Alberta Health Care Insurance Act* discussed in this report.
[61] HA, *supra* note 25. See Appendix A for a full list of relevant sections of the *Hospital Act* discussed in this report.

The *A-HCIA* implements the single-payer system with respect to physician services and dental-surgical services, while the *Hospitals Act* does so in respect of hospital services. Both statutes have to be read in conjunction with the *Health Care Protection Act*,[62] which deals with the funding and delivery of insured and uninsured surgical services and with the role in the provision of these services of private surgical facilities.

The *A-HCIA* establishes the Alberta Health Care Insurance Plan.[63] It stipulates that the Minister who is determined under the *Government Organization Act*[64] to be the Minister responsible for the Act is the public authority responsible for the administration and operation of the Plan.[65] This Minister is the Minister of Alberta Health and Wellness. The Minister is required by the *A-HCIA* to operate the Plan on a non-profit basis.[66]

The *Hospitals Act*[67] establishes the Hospitalization Benefits Plan. This Plan is administered by the Minister responsible for the *Hospitals Act*, which under regulations made under the *Government Organization Act*[68] is again the Minister of Alberta Health and Wellness.

Taken together, these provisions of the *A-HCIA* and of the *Hospitals Act* address the public administration criterion for medical and hospital services.

Both Plans apply to residents of Alberta. "Resident of Alberta" is defined in both the *A-HCIA* and in the *Hospitals Act* as it is in the *Canada Health Act*: a person "entitled by law to reside in Canada who makes the person's home and is ordinarily present in Alberta, but does not include a tourist, transient or visitor to Alberta".[69] Under both

[62] *Health Care Protection Act*, RSA 2000, c H-1 [A-HCPA]. See Appendix A for a full list of relevant sections of the *Health Care Protection Act* discussed in this report.
[63] *A-HCIA, supra* note 25, s 3(1).
[64] *Ibid,* s 1(o). *Government Organization Act*, RSA 2000, c G-10 [GOA]. *Designation and Transfer of Responsibility Regulation*, AR 80/2012, s 9 [DTRR].
[65] *A-HCIA, supra* note 25, s 3(3).
[66] *Ibid,* s 3(1).
[67] *HA, supra* note 25 at Part 3, ss 36-47.
[68] *GOA* and *DTRR, supra* note 64.
[69] *A-HCIA, supra* note 25, s 1(x); and *HA, supra* note 25, s 1(p). The applicability of the Plan established by the *A-HCIA* to residents of Alberta (as defined) is found in sections 3 and 4 of the Act. The applicability of the Plan established

Acts, a resident is not entitled to benefits if they have not completed the waiting period prescribed by regulations.[70]

Under the *A-HCIA,* a resident is also not entitled to receive benefits if they are a member of the Canadian Forces, a member of the RCMP, or a federal inmate.[71] It would appear that the same exclusions apply under the *Hospitals Act*, either under an Agreement that was made between Alberta and Canada in 1980 that is referenced in the Act and/or under sub-section 4(2) of the *Hospitalization Benefits Regulation*, which says, in effect, that services a resident is entitled to receive under "any statute of the Parliament of Canada" are not insured services.[72] The exclusion of members of the RCMP will presumably be revoked to reflect the recent amendment to the *Canada Health Act*, mentioned above, which repeals the exclusion of members of the RCMP from the definition of insured person.

The scope of the services included in the Alberta Health Care Insurance Plan under the *A-HCIA* is broader than the physician and dental-surgical services that are encompassed by the *Canada Health Act*. The function of the Plan is to "provide benefits for basic health services to all residents of Alberta".[73] "Basic health services" are then defined to include "insured services" and dental surgical services as specified in the regulations, plus optometric services, chiropractic services, podiatrist services, and "services classified as basic services by the regulations".[74]

Insured services are, in turn, defined to mean "all services provided by physicians that are medically required", dental surgical services that are specified in the regulations, and "other services that are declared by regulation to be insured services".[75] As contemplated in the *Canada Health Act*, the definition excludes services that a person is entitled to receive under workers' compensation legislation.[76]

by the *HA* to residents of Alberta (as defined) is set out in section 38 of the *HA*.
[70] *A-HCIA, supra* note 25, ss 4(3)(d) & 16(e); and *HA*, *supra* note 25, s 43(g).
[71] *A-HCIA, supra* note 25, s 4(3).
[72] *HA, supra* note 25, s 38(1)(c). *Hospitalization Benefits Regulation,* AR 244/1990 at s 4(2) [HBR].
[73] *A-HCIA, supra* note 25, s 3(1).
[74] *Ibid*, s 1(b).
[75] *Ibid*, s 1(n).
[76] *CHA, supra* note 1, s 2.

The responsibility of the Minister to pay benefits under the *A-HCIA* is broader than that of the Alberta Health Care Insurance Plan. The Minister is to pay benefits in respect of "health services", a concept which includes basic services, and thus insured services, but also "optional health services" (to be specified in regulations) and "extended health services", which are services specified in regulations for people who are or have a partner over 65 or who are in receipt of a widow's pension.[77] By contrast, the responsibility of the Health Care Insurance Plan is to "provide benefits for basic health services".

Careful attention must therefore be paid to whether specific provisions of the *A-HCIA* are applicable to:

a) all health services (which includes all basic services and all insured services);

b) all basic services (which includes all insured services); or

c) only to insured services.

For example, the provisions of the Act that prohibit extra-billing and user charges apply only to insured services and not to the other services that are funded as basic services or as health services. In contrast, the exclusion of the Members of the Canadian Forces, federal inmates and persons who have not completed the residency requirement applies to all health services.

What matters from a *Canada Health Act* perspective is whether the Plan satisfies the requirements of the *Canada Health Act* in respect of medically required physician and medically required dental-surgical services that have to be provided in a hospital.

The effect of the *A-HCIA* in placing the physician services that are to be publicly funded on "uniform terms and conditions" into the broader category of "basic health care services" may be to emphasize that the services that are insured in accordance with the *Canada Health Act* are those that are truly necessary. They do not include all services that physicians may safely and ethically be able to offer

[77] *A-HCIA*, *supra* note 25, s 1(m).

and that people may desire in addition to those that are strictly necessary.[78]

Under the *Hospitals Act*, insured services are those listed in the list of services found in that Act's definition of "standard ward hospitalization".[79] This list is supplemented by a more specific list of insured hospital services that is found in the *Hospitalization Benefits Regulation*.[80]

The more general list found in the *Hospitals Act* maps closely onto the list of services that are included in the definition of hospital services found in the *Canada Health Act*.[81] The differences again reflect the emphasis that the Alberta legislative framework seems to place on the necessity of the services. For example, while the *Canada Health Act* lists "nursing services", the *Hospitals Act* lists "necessary nursing services".[82] Like the definition of insured services under the *Alberta Health Care Insurance Act*, the *Hospitals Act* definition excludes services that residents of Alberta are entitled to receive under workers' compensation legislation.[83]

Alberta legislation complies with the *Canada Health Act* in prohibiting extra-billing and user fees. Under the *Hospitals Act* and the *Hospitalization Benefits Regulation*, the prohibition of user fees is done by clear implication: every resident of Alberta is entitled to receive insured hospital services. The Regulations then itemize the fees that hospitals can charge without conferring any authority to charge fees for the provision of what are defined as insured services.[84]

Under the *A-HCIA*, physicians and dentists may not, in the provision of insured services, charge or collect from any person (i.e. the patient or a third-party insurer) "an amount in addition to the benefits payable by the Minister for those insured services".[85] The *A-HCIA* also prohibits the charging or collecting "by any person" of an amount as a condition for receiving an insured service or for goods and

[78] *Ibid*, s 1(b).
[79] *HA, supra* note 25, s 36(j).
[80] *HBR, supra* note 72, s 4(1).
[81] *CHA, supra* note 1, s 1.
[82] *Ibid* and *HA, supra* note 25, s 36(j)(ii).
[83] *Ibid*, s 38(1)(b).
[84] *Ibid*, s 37(1); and *HBR, supra* note 72, s 4.
[85] *A-HCIA, supra* note 25, s 9(1).

services that are provided as a condition of receiving an insured service.[86]

i) Opting Out

Under the *A-HCIA*, the payment of benefits for insured services depends on the physician or dentist who provides the service being "opted in" to the Plan.[87] No physician or dentist and no resident may receive the payment of benefits under the Plan in respect of insured services unless the physician or dentist was opted in to the Plan when the services were provided.[88] The prohibition on extra-billing only applies to physicians or dentists who are "opted in" to the Alberta Health Care Insurance Plan.

Members of both professions are deemed by the Act to have "opted in" but the legislation provides procedures by which they can opt out and directly charge patients for the provision of services that they would otherwise be compensated to provide by the Plan.[89]

The opting out process operates at the level of the Plan as a whole, not at the level of specific insured services or persons or at the level of categories of insured services or persons. The result is that where a physician or dentist "opts out", the dentist or physician forgoes all opportunity to provide services for remuneration under the Plan and their patients forgo the opportunity to receive benefits under the Plan for any services received.

To ensure clarity on this point between providers and their patients, the *A-HCIA* says that where the patient of an opted out physician or dentist is entitled to receive benefits under the Plan, the physician or dentist must tell the patient before they provide the service that they have opted out and that this will mean that the patient will not be eligible to receive those benefits.[90]

The only exception is where an insured service is provided by an opted out physician or dentist on an emergency basis.

[86] *Ibid*, s 11(a) & (b).
[87] *Ibid*, s 6(1).
[88] *Ibid*, s 6(2).
[89] *Ibid*, ss 7(1) & 8(1).
[90] *Ibid*, ss 7(4)(b) & 8(4)(b).

In light of these provisions, it can be said that under Alberta legislation it is open to Alberta doctors and dentists to make services that are available to all Albertans on uniform terms and conditions through Medicare available on different and possibly preferential terms to Albertans who are able and prepared to pay for services on this basis.

Alberta's legislation also contains provisions that recognize that a person entitled to be an insured person may choose not to participate in Medicare. A provision of the *A-HCIA* reads as follows: "Nothing in this Act or the regulations is to be construed to prevent any resident who does not desire to claim or receive benefits for health services provided to the resident or resident's dependents from assuming the responsibility for the payment of those costs".[91] Similarly, a provision in the *Hospital Act* says, "Nothing in this Part [Part 3, which establishes the Hospitalization Benefits Plan] is to be construed to prevent a person who does not desire to receive insured services as provided pursuant to this Part from assuming the entire responsibility for the payment of the costs of the person's hospital services".[92]

At the same time, it is clear that Alberta's legislation is designed to discourage doctors and dentists from opting out of Medicare. As indicated above, they must opt out on a global basis and thereby forego all remuneration under the Health Care Insurance Plan.

The disincentive for "going private" that the opting out requirement creates for physicians may be reinforced in Alberta (and in other provinces) by the way the opting out procedure is structured. The physician who opts out must place a notice to that effect in a general circulation newspaper.[93]

The disincentive is also reinforced by provisions that seem clearly designed to limit the market available to opted out physicians. For example, as noted earlier, the *A-HCIA*, like the health-care insurance legislation of a number of provinces, contains a provision that prohibits insurers from entering into contracts that provide residents with prepaid basic health services or with indemnification "for all or

[91] *Ibid*, s (21)(2).
[92] *HA, supra* note 25, s 40.
[93] *Ibid*, s 8(3)(b).

part of the cost of any basic health services or extended health services".[94] Given the definition of "basic health services", this prohibition applies to what the *A-HCIA* defines as insured health services.[95]

In these respects, Alberta legislation is consistent with that in place in other provinces. With the exception of Newfoundland and Labrador, all provinces require physicians either to opt in or out of their health care insurance plan and all apply restrictions on opted out physicians that are intended to discourage physicians from making that choice. This legislative consistency has been interpreted at a national level as being designed to permit private purchase of insured medical and hospital services, while discouraging and inhibiting the growth of a private market for those services.[96] This seems to be the effect produced in Alberta: the most recent annual report of Health Canada on the *Canada Health Act* says: "As of March 31, 2011, there were zero opted out physicians in [Alberta]".[97]

There would seem to be at least two interrelated policy rationales for discouraging opting out by the providers of insured services. The first would be to minimize the extent to which those who have access to insured physician services through Medicare have preferential access to those services outside of Medicare. This rationale aligns with the concern of the *Canada Health Act* and of Alberta legislation with access to medical and hospital services on "uniform terms and conditions".

The second policy rationale would be to ensure that physician resources are overwhelmingly dedicated to making medical and hospital services available through Medicare on "uniform terms and conditions". This rationale aligns with the concern of the *Canada Health Act* and of Alberta legislation to ensure that access on uniform terms and conditions is reasonable.

[94] *Ibid*, s 26(2).
[95] A parallel provision is found in section 44 of the *HA*, *supra* note 25.
[96] Flood & Archibald, *supra* note 26.
[97] *CHA Report*, *supra* note 15 at 96.

b) The Health Care Protection Act

Alberta's legislative framework includes the *Health Care Protection Act.*[98] This Act establishes a legislative framework for the provision of surgical services that operates in conjunction with the broader legislative frameworks set up by the *A-HCIA* and the *Hospitals Act*.

The preamble to the *Health Care Protection Act* states that, "the Government of Alberta is committed to the principles of universality, comprehensiveness, accessibility, portability and public administration, as described in the *Canada Health Act*".[99] The preamble also says that "the Government of Alberta is committed to ensuring that no person who is entitled to an insured surgical service be required to pay for that service or be given priority for that service by reason of the payment of money or other valuable consideration".[100] The *Health Care Protection Act* also contains a number of operational provisions, including a prohibition of queue jumping, that are intended to maintain equality of access in respect of insured surgical services.[101]

The *Health Care Protection Act* applies the distinction between insured services (for which patients cannot be charged) and uninsured services (for which patients can be charged) that is found in the *A-HCIA* to surgical services. It also introduces a new distinction between insured services and "enhanced medical goods or services" which can be purchased by patients with, or independently of, insured services.[102]

The Act also establishes a process for approval of the establishment of non-hospital surgical facilities and for the regulation of their ongoing operation.

In general terms, subject to the limitation that major surgical services can only be provided in public hospitals and to other requirements discussed below, the *Health Care Protection Act* says that insured surgical services, uninsured surgical services and enhanced medical goods or services (along with non-medical goods and services) can be delivered under the same funding rules either in public hospitals or in

[98] *A-HCPA, supra* note 62.
[99] *Ibid* at Preamble.
[100] *Ibid.*
[101] *Ibid*, s 1-4.
[102] *Ibid*, s 5(1) & ss 29(f) & (i).

surgical facilities (clinics) that are accredited by the College of Physicians and Surgeons of Alberta and designated by the Minister of Health and Wellness.

Overall, the expressed intent of the *Health Care Protection Act* is to ensure that access to insured surgical services in a delivery system that includes private clinics is in accordance with the *Canada Health Act*.

i) How the Health Care Protection Act *Works*

The *Health Care Protection Act* provides for the establishment, operation and continuing regulation of private surgical clinics, called surgical facilities. It draws a distinction between such facilities and hospitals by prohibiting the operation of private hospitals in Alberta.

The Act limits the range of surgical services that can be provided in surgical facilities by saying that no major surgical service may be provided except in a public hospital and by defining "surgical facility" to mean "a facility whose primary function is to provide a limited range of surgical services".[103] The Act leaves responsibility for determining the services that are major surgical services to the College of Physicians and Surgeons of Alberta, exercising their by-law-making authority under the *Health Professions Act*.[104]

The Act requires all surgical facilities to be approved. It establishes two levels or classes of approved facility: (a) those that are accredited by the College of Physicians and Surgeons (or by the dental facilities accreditation committee in the case of dental surgical facilities), and (b) those that are both accredited by the College and also designated by the Minister of Health and Wellness. The latter are called "designated surgical facilities".[105]

Only surgical facilities that are "designated" can provide insured surgical services. Insured surgical services are defined as surgical

[103] *Ibid*, s 5(1) & ss 29(f) & (i).
[104] *Health Professions Act*, RSA 2000 c H-7 at Schedule 21; *Health Care Protection Regulations*, AR 208/2000, ss 2 & 3. See also the College of Physicians and Surgeons of Alberta, *By-Law: Addendum No. 1-12* (Edmonton: 1 January 2012) at section 36.
[105] *A-HCPA, supra* note 62, s 29(e).

services provided in "circumstances under which a benefit is payable" under the *A-HCIA*.[106]

The authority of designated surgical facilities to provide insured surgical services is subject to the limitation that no surgical facility can provide major surgical services. It is also subject to the requirement that the facility has an agreement with a health authority to provide facility services in respect of the provision of insured services on behalf of and for payment from the authority. Such agreements must be approved by the Minister of Health and Wellness. Under the consolidation of regional health authorities that took place in 2008, there is now only one health authority in Alberta – Alberta Health Services.[107]

Designated surgical services can also provide uninsured surgical services. These are defined as services provided in "circumstances under which no benefit is payable under the *Alberta Health Care Insurance Act*".[108]

Uninsured surgical facilities are sub-divided into two categories: (a) uninsured in-patient surgical services, and (b) uninsured day surgical services.

The basic difference between these two categories of uninsured service is that uninsured in-patient surgical services are those requiring "a medically supervised post-operative period of care exceeding 12 hours" whereas uninsured day surgical services are those that require no or a shorter period of medically supervised

[106] *Ibid*, s 29(i).

[107] In 2008, Alberta's Minister of Health and Wellness adopted several Ministerial Orders under the *Regional Health Authorities Act,* RSA 2000, c R-10, that "de-established" all of the previously existing regional health authorities and transferred their responsibilities, assets, contracts, liabilities, and employment relationships to one province-wide health authority that is called Alberta Health Services; see MO #93/2008, online: <http://www.health.alberta.ca/documents/MO-93-2008-AHSB.pdf>.

[108] *A-HCPA, supra* note 62, s 29(s). Under the *A-HCIA*, the line between insured and uninsured services is drawn in detail in the *Alberta Health Care Insurance Regulation* (which lists services that are not considered to be basic services and therefore cannot be insured services under the *A-HCIA*) and the *Medical Benefits Regulation* (which establishes the benefits payable for insured medical services). Both regulations operate under the governing concept of medical necessity as set out in the *A-HCIA* in accordance with the *Canada Health Act*.

post-operative care.[109] Surgical facilities that are accredited by the College of Physicians and Surgeons, but not "designated" by the Minister of Health and Wellness, can provide uninsured day surgical services, but not uninsured in-patient surgical services.

Both kinds of surgical facilities (as well as public hospitals) can provide "enhanced medical goods and services". These are defined as, "medical goods and services that exceed what would normally be used *in a particular case* in accordance with generally accepted medical practices".[110] These are uninsured services for which patients can be charged. The legislative establishment or recognition of this category of medical services reinforces the implication of the language used in the *Alberta Health Care Insurance Act* – that insured services are *basic* health care services. The other significant aspect of the definition is that the italicized words imply that the decision of what is enhanced and therefore uninsured gets made on a case-by-case basis, largely by treating physicians.[111]

In summary, subject to the overriding rule that major surgical services can only be provided in a public hospital and the approval and other requirements set out in the Act, the system created by the *Health Care Protection Act* can be described as follows:

- Uninsured day surgery can be provided in a public hospital or an approved surgical facility, meaning either a facility that is accredited by the College of Physicians and Surgeons or a designated surgical facility that is both accredited by the College and designated (approved) by the Minister;
- Uninsured in-patient surgical services can be provided in a public hospital or a designated surgical facility;
- Insured surgical services can be provided in a public hospital or in a designated surgical facility if the facility has an agreement to provide such services with Alberta Health Services that has been approved by the Minister of Health and Wellness; and

[109] *A-HCPA, supra* note 62, s 29(s)(ii).
[110] *Ibid,* s 29(f) [emphasis added].
[111] Timothy A Caulfield, Colleen M Flood & Barbara von Tigerstrom, "Comment: Bill 11, *Health Care Protection Act*" (2000) 9:1 Health Law Review 22-27.

- Enhanced medical goods and services, as well as non-medical goods and services, can be provided in public hospitals and in both kinds of surgical facilities.

iv) Medicare Protection Provisions in the Health Care Protection Act

When adopted, the *Health Care Protection Act* gave rise to a number of concerns about its implications for Medicare.[112] For example, there was concern it would encourage the growth of a private clinic sector that would compete with the public sector for medical and other health human resources, thus reducing the capacity of the public sector to provide reasonable access on uniform terms and conditions to a comprehensive range of medical and hospital services. Another concern was that the availability of both insured services and enhanced medical goods and services from designated surgical facilities would result in necessary medical services being distributed as enhanced medical goods and services and, therefore, outside of the *Canada Health Act* and its principle of equal access based on relative need.

The *Health Care Protection Act* contains a number of provisions to guard against these and related concerns. Some of these provisions deal directly with the risk that the Act will operate inconsistently with the *Canada Health Act* and its underlying policy objectives and others address this risk more indirectly.

One of the direct provisions says that the Minister is not to approve an agreement between a health authority and a designated surgical facility for the provision of insured surgical services by the facility unless satisfied of a number of factors. The Minister must, for example, be satisfied that the provision of the insured services by the facility "would be consistent with the *Canada Health Act*"[113] and would not have "an adverse impact on the publicly funded and publicly administered health system in Alberta".[114]

The Minister must also be satisfied that there is a current and ongoing need for the services to be provided by the facility.[115] In addition, the

[112] Sujit Choudhry, "Bill 11, the *Canada Health Act* and the Social Union: The Need for Institutions" (2003) 38:1 Osgoode Hall Law Journal 39.
[113] *A-HCPA, supra* note 62, s 8(3)(a).
[114] *Ibid,* s 8(3)(c).
[115] *Ibid,* s 8(3)(b).

Minister must be satisfied that the proposed agreement has made provision for monitoring physician compliance with the *Health Professions Act*, College by-laws, and ethical codes and standards of practice "as they relate to conflict of interest and other ethical issues".[116]

The *Health Care Protection Act* also contains a number of specific prohibitions that deal directly with behaviours or practices that could result in preferential access to insured surgical services. Specifically, it prohibits:

- queue-jumping by prohibiting anyone (including a public hospital or those working in a public hospital) from accepting money or other valuable consideration, or paying for or accepting payment for an enhanced medical good or service or non-medical goods and services, or providing an uninsured service, for the purpose of giving any person a priority for receipt of an insured surgical service;[117]
- designated surgical facilities providing an insured service from charging the patient an amount for facility services that is additional to the amount that the facility receives for those services under its regional health board agreement;[118]
- surgical facilities (and public hospitals) from charging for enhanced medical goods and services or non-medical goods and services that are provided in connection with the provision of an insured service unless the facility (or the hospital) explains the enhanced or non-medical goods or services and gets the patient's agreement in writing to accept and to pay for the services;[119] and
- the charging of fees for enhanced medical goods and services greater than the cost of the service plus a reasonable allowance for administration.[120]

[116] *Ibid*, s 8(3)(g).
[117] *Ibid*, s 3.
[118] *Ibid*, s 4(b).
[119] *Ibid*, s 5(3)(a), (b) & (c). In the case of enhanced medical goods and services, the explanation must cover the reason for the service, the price of the service, and that the service is not part of the medically required service.
[120] *Ibid*, s 5(2).

The prohibition on queue-jumping is similar to the prohibition on queue jumping found in the general health insurance legislation of at least one other province.[121]

The prohibition on facility fees extends the prohibition on user fees from the public hospital sector to the surgical facilities sector. The "price cap" on enhanced medical goods and services limits the extent of the financial incentive to encourage patients to purchase such services.

More indirectly, the prohibition against the provision of major surgical services in surgical facilities may function as a broader and more structural protection against the concern that the *Health Care Protection Act* could adversely affect access to insured services in the publicly funded system. This prohibition protects public safety. But by limiting the scale of the surgical facilities sector, it may also play a role in limiting the resources that the sector can draw from the public sector. The same comment applies to the definition of a surgical facility as "a facility whose primary function is to provide a limited range of surgical services".[122] Of course, the impact of these provisions greatly depends on how "major surgical service" is defined in the by-laws that the independent College of Physicians and Surgeons is authorized to adopt under the *Health Professions Act.*[123]

In summary, the *Health Care Protection Act* contains a number of provisions that tackle concerns about its compatibility with the *Canada Health Act* and its underlying policy objectives from multiple directions.

CONCLUSION

The *Canada Health Act* and Alberta legislation that establish two health care insurance plans are designed to ensure that Albertans, with some limited exceptions, have access to medically necessary medical and hospital services under "uniform terms and conditions".

[121] *Health Professions Act,* RSA 2000, c H-7. See also College of Physicians and Surgeons of Alberta, *By-Law: Addendum No. 1-12* (1 January 2012) section 36.
[122] *A-HCPA*, *supra* note 62, s 29(q).
[123] *Health Professions Act,* RSA 2000, c H-7. See also College of Physicians and Surgeons of Alberta, *By-Law: Addendum No. 1-12* (1 January 2012) section 36.

Specifically, the legislation and the two health care insurance plans are designed to ensure that these uniform terms and conditions have nothing to do with ability to pay or with the range of factors that a system of private health care insurance would take into account in determining eligibility for coverage and individual premiums.

Medical or hospital services provided as a benefit under workers' compensation legislation or to members of the Canadian Forces, federal inmates or new residents of Alberta are excluded from this framework. For the most part, the rationale for these exclusions is that people in each of these categories will receive access to medical and hospital services from other sources of public funds. This assumption will not apply to some of those excluded on grounds of residency. For some of those to whom the assumption is applicable, exclusion from Alberta's two health insurance plans can mean that the consistency of the terms and conditions under which they receive access to those under which others receive the service as an insured service is not relevant to compliance with the *Canada Health Act*.

Changes in medical technology that have made it possible to provide sophisticated kinds of diagnostic services outside of hospitals have created a difference in views as to when diagnostic services are and are not subject to the *Canada Health Act*.

Alberta has recognized the reality that changes in medical technology have also made it possible for certain surgical services to be provided outside of hospitals by establishing a legislative framework for the operation of private surgical facilities. This framework stresses consistency with the *Canada Health Act* and its core policy objectives of universal and reasonable access on uniform terms and conditions to all insured services.

LEGISLATIVE APPENDIX

i) Canada Health Act *(RSC 1985, c C-6)*

INTERPRETATION

2. In this Act,

"extended health care services" means the following services, as more particularly defined in the regulations, provided for residents of a province, namely,

(a) nursing home intermediate care service,

(b) adult residential care service,

(c) home care service, and

(d) ambulatory health care service;

"extra-billing" means the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist in an amount in addition to any amount paid or to be paid for that service by the health care insurance plan of a province;

"health care insurance plan" means, in relation to a province, a plan or plans established by the law of the province to provide for insured health services;

"insured health services" means hospital services, physician services and surgical-dental services provided to insured persons, but does not include any health services that a person is entitled to and eligible for under any other Act of Parliament or under any Act of the legislature of a province that relates to workers' or workmen's compensation;

"insured person" means, in relation to a province, a resident of the province other than

(a) a member of the Canadian Forces,

(b) [Repealed, 2012, c. 19, s. 377],

(c) a person serving a term of imprisonment in a penitentiary as defined in the *Penitentiary Act*, or

(d) a resident of the province who has not completed such minimum period of residence or waiting period, not exceeding three months, as may be required by the province for eligibility for or entitlement to insured health services;

"user charge" means any charge for an insured health service that is authorized or permitted by a provincial health care insurance plan that is not payable, directly or indirectly, by a provincial health care insurance plan, but does not include any charge imposed by extra-billing.

CANADIAN HEALTH CARE POLICY

Primary objective of Canadian health care policy

3. It is hereby declared that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.

PROGRAM CRITERIA

Program criteria

7. In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, the health care insurance plan of the province must, throughout the fiscal year, satisfy the criteria described in sections 8 to 12 respecting the following matters:

(a) public administration;

(b) comprehensiveness;

(c) universality;

(d) portability; and

(e) accessibility.

Public administration

8. (1) In order to satisfy the criterion respecting public administration,

(a) the health care insurance plan of a province must be administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province;

(b) the public authority must be responsible to the provincial government for that administration and operation; and

(c) the public authority must be subject to audit of its accounts and financial transactions by such authority as is charged by law with the audit of the accounts of the province.

Comprehensiveness

9. In order to satisfy the criterion respecting comprehensiveness, the health care insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners.

Universality

10. In order to satisfy the criterion respecting universality, the health care insurance plan of a province must entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions.

Portability

11. (1) In order to satisfy the criterion respecting portability, the health care insurance plan of a province

(a) must not impose any minimum period of residence in the province, or waiting period, in excess of three months before residents of the province are eligible for or entitled to insured health services;

(b) must provide for and be administered and operated so as to provide for the payment of amounts for the cost of insured health services provided to insured persons while temporarily absent from the province on the basis that

(i) where the insured health services are provided in Canada, payment for health services is at the rate that is approved by the health care insurance plan of the province in which

the services are provided, unless the provinces concerned agree to apportion the cost between them in a different manner, or

(ii) where the insured health services are provided out of Canada, payment is made on the basis of the amount that would have been paid by the province for similar services rendered in the province, with due regard, in the case of hospital services, to the size of the hospital, standards of service and other relevant factors; and

(c) must provide for and be administered and operated so as to provide for the payment, during any minimum period of residence, or any waiting period, imposed by the health care insurance plan of another province, of the cost of insured health services provided to persons who have ceased to be insured persons by reason of having become residents of that other province, on the same basis as though they had not ceased to be residents of the province.

Requirement for consent for elective insured health services permitted

(2) The criterion respecting portability is not contravened by a requirement of a provincial health care insurance plan that the prior consent of the public authority that administers and operates the plan must be obtained for elective insured health services provided to a resident of the province while temporarily absent from the province if the services in question were available on a substantially similar basis in the province.

Definition of "elective insured health services"

(3) For the purpose of subsection (2), “elective insured health services” means insured health services other than services that are provided in an emergency or in any other circumstance in which medical care is required without delay.

Accessibility

12. (1) In order to satisfy the criterion respecting accessibility, the health care insurance plan of a province

(a) must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons;

(b) must provide for payment for insured health services in accordance with a tariff or system of payment authorized by the law of the province;

(c) must provide for reasonable compensation for all insured health services rendered by medical practitioners or dentists; and

(d) must provide for the payment of amounts to hospitals, including hospitals owned or operated by Canada, in respect of the cost of insured health services.

Order reducing or withholding contribution

15. (1) Where, on the referral of a matter under section 14, the Governor in Council is of the opinion that the health care insurance plan of a province does not or has ceased to satisfy any one of the criteria described in sections 8 to 12 or that a province has failed to comply with any condition set out in section 13, the Governor in Council may, by order,

(a) direct that any cash contribution to that province for a fiscal year be reduced, in respect of each default, by an amount that the Governor in Council considers to be appropriate, having regard to the gravity of the default; or

(b) where the Governor in Council considers it appropriate, direct that the whole of any cash contribution to that province for a fiscal year be withheld.

EXTRA-BILLING AND USER CHARGES

Extra-billing

18. In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, no payments may be permitted by the province for that fiscal year under the health care insurance plan of the province in respect of insured health services that have been subject to extra-billing by medical practitioners or dentists.

User charges

19. (1) In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, user charges must not be permitted by the province for that fiscal year under the health care insurance plan of the province.

Deduction for extra-billing

20. (1) Where a province fails to comply with the condition set out in section 18, there shall be deducted from the cash contribution to the province for a fiscal year an amount that the Minister, on the basis of information provided in accordance with the regulations, determines to have been charged through extra-billing by medical practitioners or dentists in the province in that fiscal year or, where information is not provided in accordance with the regulations, an amount that the Minister estimates to have been so charged.

Deduction for user charges

(2) Where a province fails to comply with the condition set out in section 19, there shall be deducted from the cash contribution to the province for a fiscal year an amount that the Minister, on the basis of information provided in accordance with the regulations, determines to have been charged in the province in respect of user charges to which section 19 applies in that fiscal year or, where information is not provided in accordance with the regulations, an amount that the Minister estimates to have been so charged.

(ii) Alberta Health Care Insurance Act *(RSA 2000, c A-20)*

Definitions

1. In this Act,

(b) "basic health services" means

(i) insured services,

(ii) those services that are provided by a dentist in the field of oral and maxillofacial surgery and are specified in the regulations but are not within the definition of insured services,

(iii) optometric services,

(iv) chiropractic services,

(v) services and appliances provided by a podiatrist,

(vi) services classified as basic health services by the regulations;

(k) "extended health services" means those goods and services or classes of goods and services that are specified in the regulations and provided to a resident or the resident's dependants under section 3(2);

(m) "health services" means basic health services, optional health services and extended health services;

(n) "insured services" means

(i) all services provided by physicians that are medically required,

(ii) those services that are provided by a dentist in the field of oral and maxillofacial surgery and are specified in the regulations, and

(iii) any other services that are declared to be insured services pursuant to section 2, but does not include any services that a person is eligible for and entitled to under any Act of the Parliament of Canada or under the *Workers' Compensation Act* or any law of any jurisdiction outside Alberta relating to workers' compensation;

(x) "resident" or "resident of Alberta" means a person lawfully entitled to be or to remain in Canada, who makes the person's home and is ordinarily present in Alberta and any other person deemed by the regulations to be a resident, but does not include a tourist, transient or visitor to Alberta.

Part 1

Health Care Insurance

Operation of Plan

3(1) The Minister shall, in accordance with this Act and the regulations, administer and operate on a non-profit basis a plan to provide benefits for basic health services to all residents of Alberta.

Coverage under Plan

4(1) Subject to this Act and the regulations, the Minister shall pay benefits in respect of health services provided to residents.

(2) All claims for benefits are subject to assessment and approval by the Minister and the amount of the benefits to be paid and the person to whom the benefits are to be paid shall be determined in accordance with the regulations.

(3) A resident is not entitled to the payment of benefits in respect of health services provided to the resident if the resident is

(a) a member of the Canadian Forces,

(b) a member of the Royal Canadian Mounted Police who is appointed to a rank in it,

(c) a person serving a term of imprisonment in a penitentiary as defined in the *Corrections and Conditional Release Act* (Canada), or

(d) a resident who has not completed the waiting period prescribed by the regulations.

(4) The Minister may withhold payment of benefits for health services until the Minister is satisfied that the person was a resident at the time the services were provided.

(5) For the purposes of subsection (4), a certificate of registration under the *Health Insurance Premiums Act* is proof, in the absence of evidence to the contrary, that the person is a resident if the certificate was in effect at the time the service was provided to that person.

Payment of benefits

6(1) No physician or dentist may receive the payment of benefits from the Minister for insured services provided in Alberta to a resident unless the physician or dentist was opted into the Plan when the insured services were provided.

(2) No resident may receive the payment of benefits from the Minister for insured services provided in Alberta to the resident by a physician or dentist unless the physician or dentist who provided the insured services was opted into the Plan when the insured services were provided.

(3) Notwithstanding subsections (1) and (2), the Minister may pay benefits for insured services provided in Alberta to a resident by a physician or dentist who was opted out of the Plan if the insured services were provided in an emergency.

Opting in and out by physicians

8(1) Subject to this section, every physician is deemed to have opted into the Plan.

(2) A physician may opt out of the Plan by

(a) notifying the Minister in writing indicating the effective date of the opting out,

(b) publishing a notice of the proposed opting out in a newspaper having general circulation in the area in which the physician practices, and

(c) posting a notice of the proposed opting out in a part of the physician's office to which patients have access at least 180 days prior to the effective date of the opting out.

(3) A physician who has not previously practiced in Alberta may opt out of the Plan prior to commencing practice by

(a) notifying the Minister in writing indicating the date on which the physician will commence opted-out practice, and

(b) publishing a notice of the proposed opting out in a newspaper having general circulation in the area in which the physician intends to practice.

(4) A physician who has opted out of the Plan shall

(a) post a notice in a part of the physician's office to which patients have access advising patients of the physician's opted-out status, and

(b) ensure that each patient is advised in person of the physician's opted-out status before any service is provided to the patient.

Extra billing

9(1) No physician or dentist who is opted into the Plan who provides insured services to a person shall charge or collect from any person an amount in addition to the benefits payable by the Minister for those insured services.

Other prohibited fees

11(1) No person shall charge or collect from any person

(a) an amount for any goods or services that are provided as a condition to receiving an insured service provided by a physician or dentist who is opted into the Plan, or

(b) an amount the payment of which is a condition to receiving an insured service provided by a physician or dentist who is opted into the Plan where the amount is in addition to the benefits payable by the Minister for the insured service.

(2) Subsection (1) does not prohibit the charging or collecting of an amount paid for non-insured health or pharmaceutical goods or services where the charging or collecting of that amount is not otherwise prohibited under this Act or the *Hospitals Act* and a physician or dentist reasonably determines that it is necessary to provide the non-insured health or pharmaceutical goods or services before the insured service is provided.

Prohibition on receiving benefits

12(1) A physician or dentist who is opted into the Plan and provides insured services to a person in circumstances where the physician or dentist knows or ought reasonably to know that the person is being

charged an amount in contravention of section 11 shall not receive the payment of benefits from the Minister for those insured services.

(2) Section 9(2) applies where a physician or dentist contravenes subsection (1).

Minister's right to recover amounts

13(1) If a physician or dentist

(a) in contravention of section 9 or 10, receives an amount in addition to the benefits payable by the Minister, or

(b) receives the payment of benefits in contravention of section 12, the Minister may act under subsection (2).

(2) If subsection (1) applies, the Minister may recover the additional amount and the benefits in a case referred to in subsection (1)(a), or the benefits in a case referred to in subsection (1)(b), by one or more of the following means:

(a) by withholding those amounts from any benefits payable to the physician or dentist;

(b) by civil action as though those amounts were a debt owing to the Crown in right of Alberta;

(c) pursuant to any agreement between the Minister and the physician or dentist that provides for the repayment of those amounts.

(3) The Minister shall reimburse a person in respect of whom benefits may be paid for any amounts recovered under this section that were paid by the person and have not been previously reimbursed.

Duty to advise

15(1) Prior to providing insured services in Alberta to a resident in respect of whom benefits may be paid, a physician or dentist who is opted out of the Plan shall advise the resident of that fact and that the resident is not entitled to be reimbursed from the Plan for the cost of any insured services provided by the physician or dentist.

(2) This section does not apply when the insured services are provided in an emergency.

(iii) Hospitals Act *(RSA 2000, c. H-12)*

Definitions

1. In this Act,

(p) "resident of Alberta" means a person entitled by law to reside in Canada who makes the person's home and is ordinarily present in Alberta, but does not include a tourist, transient or visitor to Alberta.

Part 3

Hospitalization Benefits Plan

Definitions

36. In this Part,

(h) "insured services" means the hospital services the operating costs of which will be provided for under this Part;

(j) "standard ward hospitalization" means the following services to in-patients:

(i) accommodation and meals at the standard or public ward level;

(ii) necessary nursing services;

(iii) laboratory, radiological and other diagnostic procedures, together with the necessary interpretation, for the purpose of maintaining health, preventing disease and assisting in the diagnosis and treatment of any injury, illness or disability;

(iv) drugs, biologicals and related preparations when administered in a hospital, as specified in the Agreement;

(v) use of operating room, case room and anaesthetic

facilities, including necessary equipment and supplies, where available;

(vi) routine surgical supplies;

(vii) use of radiotherapy facilities, where available;

(viii) use of physical therapy facilities, where available;

(ix) services rendered by persons who receive remuneration for those services from the hospital.

Insured services

37(1) The insured services to be provided under this Part shall be those furnished

(a) by an approved hospital of the patient's choice, and

(b) by any other institutions or persons that are prescribed in the regulations.

(2) The insured services to be provided under this Part shall include

(a) standard ward hospitalization in an approved hospital, and

(b) any other goods and services that are prescribed in the regulations.

Entitlement to insured services

38(1) Subject to the following exclusions, a resident of Alberta is entitled to receive insured services under this Part except when, in respect of those services,

(a) the resident is or could be entitled to hospital services from another province or territory that has entered into a hospitalization plan with the Government of Canada under the *Canada Act*,

(b) the resident is entitled to receive hospital services pursuant to any workers' compensation statute of any province or territory,

(c) the resident is entitled to receive hospital services under any statute of Canada or of any province or territory of Canada, as specified in the Agreement, or

(d) the resident is declared, pursuant to Part 2, to be not in need of hospital services.

Payment for insured services

40 Nothing in this Part is to be construed to prevent a person who does not desire to receive insured services as provided pursuant to this Part from assuming the entire responsibility for the payment of the costs of the person's hospital services.

(iv) Health Care Protection Act *(RSA 2000, c H-1)*

Part 1

Protection of Publicly Funded Health Care

Operation of private hospitals prohibited

1 No person shall operate a private hospital in Alberta.

Provision of surgical services

2(1) No physician shall provide a surgical service in Alberta, and no dentist shall provide an insured surgical service in Alberta, except in

(a) a public hospital, or

(b) an approved surgical facility.

(2) No physician or dentist shall provide a major surgical service, as described

(a) in the bylaws under Schedule 21 of the *Health Professions Act*, in the case of a physician, or

(b) in the regulations under section 25(1)(b), in the case of a dentist, in Alberta, except in a public hospital.

Queue-jumping prohibited

3 No person shall

(a) give or accept any money or other valuable consideration,

(b) pay for or accept payment for enhanced medical goods or services or non-medical goods or services, or

(c) provide an uninsured surgical service for the purpose of giving any person priority for the receipt of an insured surgical service.

Facility services

4 Where a person receives an insured surgical service at a designated surgical facility,

(a) the operator of the surgical facility shall provide facility services to the person, and

(b) no person shall charge or collect any amount in respect of the provision of facility services that is in addition to the amount that is payable for the facility services by the health authority under an agreement referred to in section 8.

Provision of goods or services

5(1) No person shall require a person who receives an insured surgical service at a public hospital or a designated surgical facility to pay for

(a) enhanced medical goods or services, or

(b) non-medical goods or services,

that are provided in connection with the provision of the insured surgical service or that arise out of the stay at the public hospital or designated surgical facility, unless subsections (3) and (4) have been complied with.

(2) No person shall charge or collect a rate for enhanced medical goods or services that is greater than cost plus a reasonable allowance for administration.

(3) Before any enhanced medical goods or services are provided to a person,

(a) the nature of the enhanced medical goods or services being offered and the charges for them must be fully explained to the person,

(b) the person must be presented with a statement signed by the physician or dentist who will be providing the insured surgical service that

(i) explains the nature of the enhanced medical goods or services to be provided,

(ii) explains why the physician or dentist is offering the enhanced medical goods or services,

(iii) explains that the enhanced medical goods or services are not part of the medically required service,

(iv) sets out the charges for the enhanced medical goods or services, and

(v) meets any other requirements of the regulations, and

(a) the person must have agreed in writing to accept and pay for the enhanced medical goods or services.

(4) Before any non-medical goods or services are provided to a person, the nature of the goods or services and the charges for them must be fully explained to the person and the person must have agreed in writing to accept and pay for the goods or services.

(5) A person who has agreed to accept and pay for enhanced medical goods or services or non-medical goods or services may, in accordance with the regulations, rescind the agreement before the goods or services are provided.

(6) Where a person is provided

(a) with an enhanced medical good or service because the public hospital or designated surgical facility does not have available the medical good or service that would normally be used in accordance with generally accepted medical practice, or

(b) with a private or semi-private room because the public hospital or designated surgical facility does not have standard ward accommodation available,

the person is not responsible for the extra cost of having the enhanced medical good or service or the private or semi-private room provided.

Conditions of operation

7 No person shall operate a surgical facility at which insured surgical services are provided unless

(a) the surgical facility is accredited as required by section 11(1)(b),

(b) the operator of the surgical facility has an agreement with a health authority that the Minister has approved under section 8, and

(c) the surgical facility is designated under this Division.

Approval of agreement

8(1) A health authority that wishes to enter into an agreement with an operator of a surgical facility for the purpose of providing facility services that are required in connection with the provision of insured surgical services shall provide the Minister with a copy of the proposed agreement for the Minister's approval.

(2) The Minister may

(a) refuse to approve a proposed agreement, or

(b) approve a proposed agreement, subject to any terms or conditions that the Minister considers appropriate.

(3) The Minister shall not approve a proposed agreement unless the Minister is satisfied

(a) that the provision of insured surgical services as contemplated under the proposed agreement would be consistent with the principles of the *Canada Health Act* (Canada),

(b) that there is a current need and that there will likely be an ongoing need in the geographical area to be served for the provision of insured surgical services as contemplated under the proposed agreement,

(c) that the provision of the insured surgical services as contemplated under the proposed agreement would not have an adverse impact on the publicly funded and publicly administered health system in Alberta,

(d) that there is an expected public benefit in providing the insured surgical services as contemplated under the proposed agreement, considering factors such as:

(i) access to such services,

(ii) quality of service,

(iii) flexibility,

(iv) the efficient use of existing capacity, and

(v) cost effectiveness and other economic considerations.

Designation of facility

15(1) On considering the proposal and the following factors, the Minister may by order designate the surgical facility as a surgical facility for the purposes of this Division:

(a) whether the provision of the uninsured in-patient surgical services as contemplated in the proposal would have an adverse impact on the publicly funded and publicly administered health system in Alberta or impair the government's ability to comply with the *Canada Health Act* (Canada);

(b) whether the public interest would be served by the designation of the surgical facility;

(c) any other factors the Minister considers appropriate.

(2) The Minister shall not designate the surgical facility unless the Minister is satisfied that the surgical facility is accredited to provide the uninsured in-patient surgical services referred to in the proposal, or that it will be accredited before any such services are provided.

(3) A designation must describe the uninsured in-patient surgical services that the designated surgical facility is authorized to provide.

Disclosure requirement

17 Where a person receives an uninsured surgical service at a public hospital or an approved surgical facility in circumstances under which that person is expected to pay for the uninsured surgical service, no person shall require that person to pay for the uninsured surgical service or for any facility services unless, before the uninsured surgical service is provided, the nature of the uninsured surgical service and facility services to be provided and the charges for them are fully explained to the person and the person agrees in writing to accept and pay for them.

Part 5

Definitions

29 In this Act,

(a) "approved surgical facility" means a designated surgical facility and a surgical facility referred to in section 16;

(b) "designated surgical facility" means a surgical facility that is designated under Part 2, Division 1 or 2, as the context requires;

(c) "enhanced medical goods or services" means medical goods or services that exceed what would normally be used in a particular case in accordance with generally accepted medical practice;

(d) "facility services" means any of the following services that are medically necessary and are directly related to the provision of a surgical service at an approved surgical facility:

(i) standard ward accommodation, or a semi-private or private room where the patient's condition requires it;

(ii) meals;

(iii) necessary nursing services, including private nursing care where ordered by the attending physician or dentist;

(iv) laboratory, radiological and other diagnostic procedures, together with the necessary interpretations;

(v) drugs, biologicals and related preparations when administered in the surgical facility;

(vi) use of operating room, case room and anesthetic facilities, including necessary equipment and supplies;

(vii) use of physical therapy services;

(viii) use of surgical equipment and supplies;

(ix) medical goods or services consistent with generally accepted medical practice in the particular case;

(x) transportation by ambulance or commercial vehicle of a patient from the surgical facility to an approved hospital under the Hospitals Act, a nursing home, a mental health facility or another surgical facility;

(xi) other services provided by persons who receive remuneration for providing the services directly or indirectly from the operator of the surgical facility;

(xii) any other service that is presented in the regulations;

(e) "health authority" means a regional health authority;

(f) "insured surgical service" means a surgical service that is provided by a physician, or by a dentist in the field of oral and maxillofacial surgery, in circumstances under which a benefit is payable under the *Alberta Health Care Insurance Act*;

(g) "private hospital" means an acute care facility thatprovides emergency, diagnostic, surgical and medical services, andadmits patients for medically supervised stays exceeding 12 hours, but does not include a public hospital.

(h) "public hospital" means

(i) a hospital that is established by or under, or the establishment or operation of which is governed by, the *Hospitals Act*, the *Regional Health Authorities Act* or the *Workers' Compensation Act*, or

(ii) a hospital that is established by the Government of Alberta or the Government of Canada.

(*v)* Hospitals Act, Hospitalization Benefits Regulation, *Alta Reg 244/1990*

Insured services

4(1) The following goods and services, in addition to standard ward hospitalization, are included in insured services under Part 3 of the Act:

(a) to in-patients,

(i) a semi-private or private room, where a patient's medical condition makes it necessary;

(ii) private nursing care for a patient where ordered by the attending physician and approved in accordance with the hospital's by-laws;

(iii) subject to subsection (2)(f) and (g), drugs, biologicals and related preparations when administered in a hospital, unless they are enhanced goods and services referred to in section 5.2;

(iv) pacemakers, steelplates, pins, joint prostheses, valve implants and any other goods approved by the Minister, unless they are enhanced goods and services referred to in section 5.2;

(v) transportation in Alberta, whether by ambulance or other commercial vehicle, to transport a patient in the circumstances described in section 6;

(vi) goods and services included in an approved hospital program or a specific program but not included in subclauses (i) to (v), unless they are enhanced goods and services referred to in section 5.2;

(vii) enhanced goods or services provided under section 5.2(2);

(b) to out-patients, any medically necessary goods and services that may be provided on an out-patient basis, including goods used in a medical procedure but excluding goods provided to a patient for use after discharge from an approved hospital or facility.

(2) The following services are not insured services:

(a) examinations required for the use of third parties, except as otherwise directed by the Minister;

(b) services that a resident is eligible to receive under a statute of any other province, any Act of Alberta relating to workers' compensation or any statute of the Parliament of Canada, including:

(i) the Aeronautics Act (Canada),

(ii) the Civilian War Pensions and Allowances Act (Canada),

(iii) the Government Employees Compensation Act (Canada),

(iv) the Merchant Seamen Compensation Act (Canada),

(v) the National Defence Act (Canada),

(vi) the Pension Act (Canada),

(vii) the Royal Canadian Mounted Police Act (Canada), and

(viii) the Veterans Rehabilitation Act (Canada);

(c) services that a resident is entitled to receive under the Alberta Health Care Insurance Act, unless approved by the Minister;

(d) services that a patient is declared not to be in need of pursuant to section 31 of the Act;

(i) those services provided by the board in connection with non-insured health services that are referred to in section 5.1;

(ii) enhanced goods and services referred to in section 5.2(1);

(e) laboratory and x-ray services performed in a facility not approved by the Minister;

(i) services provided by a facility outside of Canada (other than services provided in the case of an emergency) without the prior approval of the Minister, unless the Minister directs otherwise;

(f) any drugs, biologicals and related preparations that are not considered necessary for the proper treatment of patients

(i) by the pharmacy-therapeutic committee of any hospital,

(ii) by the joint pharmacy-therapeutic committee of The Alberta Medical Association, The Alberta Pharmaceutical Association and the Alberta Hospital Association in respect of any hospital having a rated capacity of

(A) fewer than 180 beds, or

(B) 180 beds or more if, in the opinion of that committee, this view represents the majority of the hospital pharmacy-therapeutic committees or the practising physicians in the geographic area of Alberta in which the hospital is located;

(g) any drugs, biologicals and related preparations that, in the opinion of that joint committee, have not been proven by experimental or clinical trials to be satisfactory for general use in hospitals.

(3) Notwithstanding subsection (2)(g), the joint committee may recommend limited experimental or clinical trials under close supervision in order to determine whether or not materials referred to in that clause should be approved for general use in hospitals.

How Health Care is Delivered in Alberta

J.L. Saunders

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(b) How Health Care is Delivered in Alberta

J.L. Saunders

Scope

This paper will briefly review the organization of health services in Alberta. It will summarize the legislated accountabilities and policies of the Alberta Government and Alberta Health Services as they relate to the subject of preferential access to publically funded health care services in Alberta. It will also comment on the role of physicians in the health care system and their roles related to the patient referral processes. The current patient wait list initiatives and the publically-funded and fee-based options Albertans have to access health care services will also be reviewed.

The *Canada Health Act* and the relationship between federal and provincial legislation in health care delivery has been summarized by Professor Lahey in his submission to the Inquiry and will not be repeated here.

The intent of this paper is to provide an overview of how the health care system is organized in Alberta, for the purpose of assisting the Public Inquiry. It is not intended to be an exhaustive review of health care delivery in Alberta.

1. Summary of Government and Health System Legislated Accountabilities

The roles and responsibilities of the Alberta government and Alberta Health Services (including AHS medical staff) are defined in provincial government acts and regulations. A brief review of these relationships will assist in understanding the accountabilities for setting appropriate policies, communicating expectations and monitoring compliance to assure equitable access to health services in Alberta.

1.1 *Minister of Health*

The Minister of Health ("the Minister") sets overall direction, priorities and expectations, including standards, for the provincial health system. The Minister develops the planning, policy, legislative and standards framework within which health authorities plan and deliver services. The Minister also monitors the overall health of Albertans, the factors

that affect health, and assesses the overall performance of the health system.[1]

The provincial government, through the Minister, sets provincial policy on matters to ensure that the government's expectations are met.

1.2 *Alberta Health Services ("AHS")*

Alberta Health Services, through its Board ("the AHS Board"), reports to the Minister.[2] The Minister appoints each member of the AHS Board. Board members hold office for a specified term or until removed earlier, at the discretion of the Minister.[3]

Regional health authorities (meaning Alberta Health Services at this time) have responsibilities conferred on them by the Legislative Assembly, primarily through the *Regional Health Authorities Act*.

Regional health authorities also have responsibilities under the *Hospitals Act* respecting the operation of hospital programs, the *Nursing Homes Act* respecting the operation of nursing home programs, the *Mental Health Act* respecting the admission, detention, administration and treatment and control of mental health patients, the *Public Health Act* respecting home care and the prevention of communicable diseases and health hazards, and the *Government Accountability Act* respecting the preparation of business plans and annual reports.[4]

The AHS Board is responsible for governing the AHS organization and its operating entities. The AHS Board provides vision, direction and leadership to the organization to ensure that its mandate is achieved. It governs the AHS organization by establishing policies and bylaws. It is the responsibility of management and staff to implement the policies and bylaws developed by the AHS Board.[5]

Subject to any limitations of its authority imposed by legislation and regulations, the AHS Board has full control of AHS facilities and has

[1] *Appendix A, Health Authority Accountability in Alberta's Health System, Page 2, 3.*
[2] *Appendix B, Organization Chart, Ministry of Health and Wellness, Annual Report 2010-11, Page 8.*
[3] *Appendix C, Alberta Health Services Board, 2008, M.O. #93/2008, Page 5.*
[4] *Appendix A, Health Authority Accountability in Alberta's Health System, Page 3.*
[5] *Appendix A, Health Authority Accountability in Alberta's Health System, Page 3.*

absolute and final authority in respect of all matters pertaining to the operations of its hospitals.[6]

In further detail, AHS is responsible to:

(i) promote and protect the health of the population in the health region (province of Alberta) and work toward the prevention of disease and injury;

(ii) assess on an ongoing basis the health needs of the health region;

(iii) determine priorities in the provision of health services in the health region and allocate resources accordingly;

(iv) ensure that reasonable access to quality health services is provided in and through the health region; and

(v) promote the provision of health services in a manner that is responsive to the needs of individuals and communities and supports the integration of services and facilities in the health region.

AHS has final authority in the health region, subject to the *Regional Authorities Act* and Regulations, in respect of the matters referred to in clauses (i) through (v) above.[7]

1.3 *Alberta Health Services and Covenant Health[8] Medical Staff*

The AHS, Covenant Health and their medical staff, together with their medical and administrative officers, are responsible for the provision and quality of care within these organizations. The details of these responsibilities are described in a number of documents including the Medical Staff Bylaws and Medical Staff Regulations of the respective organizations and the *Alberta Hospitals Act*. For example, the medical staff is responsible for:

[6] *Appendix D, the Alberta Hospitals Act, RSA 2000, Chapter H-12, s. 10(1) and 10 (2).*
[7] *Appendix E, Regional Health Authorities Act, RSA 2000, Chapter R-10, s. 5.5.*
[8] Covenant Health is an Alberta-based Catholic organization which provides acute care, continuing care, assisted living, hospice, rehabilitation, respite care and seniors housing in 12 communities throughout Alberta, operating approximately 946 acute care beds and 1,368 continuing care beds [Appendix H: Excerpt from Covenant Health Website] Covenant Health delivers these services under contract to AHS.

- the quality of the professional services provided by the medical staff;
- reviewing the professional practices of the medical staff;
- improvement of the care of patients under the care of the medical staff; and
- the clinical and scientific work of the medical staff.[9]

2. Governance of the Health Care System in Alberta

While the government department responsible for the oversight of the health system changed names several times over the years from Alberta Social Services and Community Health to Alberta Hospitals and Medical (1975), to Alberta Health (1988) and to Alberta Health and Wellness (1994), no major changes were made in the roles, responsibilities or accountabilities of government or the health organizations prior to 1994.

As noted in the previous section, the provincial Government is responsible for setting provincial health policy and funding levels. The appointed health care Board(s) are accountable for, among other duties, operating their facilities and meeting provincial expectations for quality, access and operating budgets.

The following is a brief review of the major changes that have taken place in the governance of the health organizations in Alberta over the past 18 years.

2.1 *Seventeen (17) Regional Health Authorities – 1994*

In May 1994 there were a total of 193 health care Boards in Alberta: 128 acute care hospital boards, 25 public health boards and 40 long term care boards.[10]

On June 24, 1994, under the authority of the Alberta *Regional Health Authorities Act,* the Minister announced that the number of health care Boards would be reduced from 193 to 17 new health region Boards. In

[9] *Appendix D, the Alberta Hospitals Act, RSA 2000, Chapter H-12, Page 10.*
[10] *Appendix F, Government of Alberta News Release, "One Provincial Board to Govern Alberta's Health System", May 15, 2008, Page 3.*

addition, the Alberta Cancer Board and the Alberta Mental Health Board would remain in place with province-wide responsibilities.

The purpose of the change was to increase efficiency of the health system.

2.2 *Nine (9) Health Regions – 2003*

The number of health regions was further reduced from 17 health regions to 9 on April 1, 2003. The Alberta Cancer Board and the Alberta Mental Health Board remained in place for a total of 11 health care entities.

This change enabled the boundaries of the large and medium sized health regions to be expanded to include smaller rural health regions whose populations were accessing and depending on health services from the larger regions. For example, the Headwaters Health Region (High River area south of Calgary) was merged into the Calgary Health Region and the West View Health Region (west of Edmonton out to Jasper) was merged into Capital Health.

The decision to make the 2003 changes was based on the idea that fewer health regions with more resources, larger budgets and responsibility for managing health services for larger catchment areas and service populations would achieve efficiencies within the system. The greater scope was expected to streamline government interaction with the health system and to improve the effective management of the health regions, quality of care, standardization of policies and procedures and coordination of services.

2.3 *One (1) Province-Wide Health Region – 2008*

The Minister announced on May 15, 2008 that Alberta would be moving to one provincial governance Board which would be tasked with co-ordinating the delivery of health services across the province.

Alberta Health Services (AHS) brought together 12 formerly separate health entities in the province: nine geographically based health authorities[11] and three provincial entities – the Alberta Mental Health

[11] Chinook Regional Health Authority, Palliser Health Region, Calgary Health Region, David Thompson Health Region, East Central Health, Capital Health, Aspen Regional Health Authority, Peace Country Health and Northern Lights Health Region.

Board, the Alberta Alcohol and Drug Abuse Commission (AADAC) and the Alberta Cancer Board.[12] Prior to the creation of AHS, the Mental Health and Cancer Boards reported to the Minister of Health while AADAC reported to the (then) Department of Health and Wellness.[13] Ground ambulance service was added to the responsibilities of AHS on May 30, 2008.[14]

One further change in the governance of the Alberta health system in 2008 was the integration of Covenant Health into a contractual working relationship with AHS. Prior to 2008, Covenant Health (then Caritas Health) had a working relationship with the (former) Capital Health Region. In 2008, it was agreed that Covenant Health would continue to operate with its own Board but that it would sign a formal cooperation and services agreement with AHS that would define funding, health care services, policy and relationship agreements.[15]

In a May 15, 2008 news release, the Minister stated that:

> the first priority in the health action plan is to improve the way health care is administered in this province....Moving to one provincial governance board will ensure a more streamlined system for patients and health professionals across the province.[16]

The news release goes on to state that the new governance model is intended to strengthen a provincial approach to managing health care services, including surgical access, long term care, chronic disease management, addictions and mental health services as well as health workforce and access to primary care.[17]

Feedback from both executive and medical managers who were working in the health system in 2008 reinforces the advantages of one provincial vision, mission and statement of priorities. The creation of AHS allowed medical and health system standards, benchmarks, quality, data collection and reporting to go to a provincial level and

[12] *Alberta Health Services Annual Report, April 1, 2008 – March 31, 2009, Page 4.*
[13] The Department of Health and Wellness is now known as the Department of Health.
[14] *Appendix G, Alberta Health Services Annual Report, April 1, 2008 – March 31, 2009, Page 6.*
[15] *Appendix I, AHS Board Meeting Minutes, December 2, 2010, Page 7-8.*
[16] *Appendix F, Government of Alberta News Release, "One Provincial Board to Govern Alberta's Health System", May 15, 2008, Page 3.*
[17] *Appendix J, Government of Alberta News Release Backgrounder, dated May 3, 2011, Page 1.*

further enhanced the opportunities to reduce administrative and back-office expenses.

A copy of the AHS executive organization chart as of October 31, 2012 is attached to this report.[18] AHS continues to evolve as an organization. Changes in 2011, for example, included some realignment of positions and responsibilities in the executive structure, introducing a shared administrative/medical decision making model, dividing the province into 5 zones[19] and delegating authority and accountability for a greater scope of decision making at the zone level. The zones were intended to create a clear, patient-focused "line of sight" between the decisions that need to be made and the people who need to make them.[20]

Another change for the health system was the approval of a first-ever 5-year funding commitment for health. The Minister's message in the 2010-11 Annual Report states: "The funding commitment provides 6 per cent operating increases in each of the first 3 years, and 4.5 per cent increases in each of the final 2 years. This 5-year funding – the first of its kind in Canada – provides AHS with a stable, predictable funding platform to enhance long-range planning."[21]

3. Ways Albertans Can Access Primary Health Care Services and Specialists

It is important to understand the options that Albertans have to gain entry into both primary and specialty health care services. The below is not a comprehensive statement of all of the possible ways that Albertans can gain access to primary care and specialists. Rather, it is intended to provide the Inquiry with a general understanding of the more common ways that Albertans access these services.

3.1 *First Point of Contact – Access to Primary Care*

There are a number of options for accessing primary health services in Alberta. Four of the most common are:

[18] *Appendix K, AHS Organizational Chart as of October 31, 2012.*
[19] *Appendix L, Map of AHS Zones.*
[20] *Appendix J, Government of Alberta News Release Backgrounder, Page 1.*
[21] *Appendix M, Health and Wellness Annual Report, 2010–11, Page 5.*

1. General Practitioners' ("GPs") offices. This could include a sole practitioner, group practice or a care delivery service organized through a Primary Care Network (a group of networked family doctors working with other health care professionals such as nurses, dieticians, pharmacists, etc. to provide care to a defined group of patients);[22]
2. Walk-in clinics;
3. Urgent Care Centers and Advanced Ambulatory Care Centers (most often located within a regional health center, they provide extended hour access for unexpected, but non-life-threatening health concerns, which require same day treatment); or
4. Hospital emergency departments ("EDs").

If the GP or ED physician determines that a patient requires care that is beyond that physician's training or expertise, the patient is referred to a medical specialist (medicine, surgery, mental health, etc.).[23]

When patients arrive at an emergency department they are prioritized and then treated according to the urgency of care they require. AHS uses the Canadian Triage and Acuity Scale ("CTAS") to assess patients triaged at Emergency Departments and Urgent Care facilities.[24] The CTAS scale is based on an acuity level between 1 and 5. Patients requiring immediate intervention and possibly resuscitation are assessed as CTAS level 1. CTAS 2 (emergent) and CTAS 3 (urgent) categories represent patients needing more timely attention than those categorized as CTAS 4 (less urgent) and CTAS 5 (non-urgent).

3.2 *Access to a Specialist*

Discussions about access to health services often relate to wait times from GP to Specialist and from Specialist to treatment. These are areas of concern for patients, government and AHS.

[22] *Appendix N, description of the Primary Care Initiative and AHS website, "Your Health Care Options".*
[23] *Appendix O, College of Physicians and Surgeons of Alberta, Standards of Practice, The Referral Consultation Process, Standard 6.*
[24] *Appendix P, AHS document titled: "How Busy Are Our Emergency Departments".*

While there are exceptions, typically patients access Specialist care through a referral from a GP, an ED physician or another Specialist.

There are generally two ways to refer a patient to a Specialist:

1. Direct referral to a specific Specialist; and
2. Referral to a group of Specialists through a Central Booking Office.

3.2.1 *Direct Referral to a Specific Specialist*

The most common form of referral is direct to a specific Specialist with whom the GP, ED physician or another Specialist has a working relationship. In the normal process, the referring physician will write a referral letter to the Specialist which summarizes the patient's history, medical symptoms, etc. The referring physician may classify the patient as routine, semi-urgent or urgent (or similar wording) and provide medical information to validate the classification. What the GP/ED physician says and the urgency that the referring physician expresses to the Specialist may act as one influencing factor for the Specialist in deciding how soon the Specialist will schedule an appointment for the patient.[25] Some Specialists have designated classification systems where GPs are required to fill out special forms that may be unique to that Specialist.

Some GPs may be more effective than others at assessing patients prior to referral, summarizing required medical information and cultivating relationships with Specialists. The effectiveness of the GP can impact the wait time for a patient to see a Specialist. For example, a phone call from the GP to the Specialist asking them to watch for a specific referral that the GP is concerned about, together with a detailed patient assessment summarizing the medical evidence may encourage the Specialist to review the patient file more quickly.

Specialists are expected to evaluate a patient's acuity and to assess the relative priority for treatment compared to other patients who are waiting for treatment on the Specialists' waiting list.

[25] *Appendix O, College of Physicians and Surgeons of Alberta, Standards of Practice, The Referral Consultation Process, Standard 6.*

3.2.2 *Referral to a group of Specialists through a Central Booking Office*

To achieve AHS's objectives of improving access and reducing wait times[26] some options have been developed related to referrals to some Specialists and speciality clinics, particularly within certain AHS Zones.

For those Specialists who agree to accept referrals through a Central Booking Office, the GP or Specialist referring to them will submit the patient's referral information to a group of Specialists as opposed to one specific Specialist. The Central Booking Office will then review the referral and will assign a Specialist within their group based on factors such as workload (next available on the list), particular skills, etc.

At the national level there are some new strategies for priority standardization in some of the specialities. One example is the Paediatric Canadian Access Targets for Surgery ("P-CATS"). One of the differentiating factors with this project is that the P-CATS are diagnosis-based, in contrast to many adult surgical access targets, which are procedure-based. Standardization across surgical subspecialties and hospitals allows for national and hospital-specific analyses, comparisons and benchmarking, since each patient with a given diagnosis will also have the same priority level. In addition, this standardization allows operating room resources to be managed across surgical subspecialties.[27]

The Central Booking Office concept is in the early stages of development. It is intended to offer advantages such as: better coordination of Specialist workloads, more efficient patient flow, standardizing treatment-specific priority-setting criteria and reduction of waiting times. Some Specialist groups, with the support of AHS in some cases, are working together on the development of alternate central booking options. Examples of the speciality services where central booking options may be in the development stages include: Orthopaedics, Gastrointestinal, Neurology, Endocrinology, Rheumatology and Cardiology.

[26] *Appendix Q, AHS Health Plan and Business Plan, 2012–2015, Page 22.*
[27] *Appendix R, P-CATS Report, November 5, 2008, Page 3.*

4. Fee-Based Options to Access Health Services

As thoroughly canvassed by Prof. Lahey, the *Canada Health Act* prohibits extra-billing by physicians[28] and user charges for any medical and related service that is defined as an insured service within the province's health care insurance plan. There are still, however, a number of options whereby Albertans can legally pay for certain health services.

4.1 *Uninsured Health Services*

Medical services that are not publically insured within the Alberta Health Care Insurance Plan (i.e. non-essential cosmetic surgery, etc.) can be legally purchased. Fees for uninsured medical services can include charges for the physician and charges for the facility (facility fee) in which the service is provided.

4.2 *No Fee Code*

Those medical services that do not have a fee code in Alberta can be legally purchased from a licensed vendor even if they are also available free of charge within the public system. Examples of this type of service are: MRIs, CT scans and ultrasounds. To access these services on a user-pay basis the patient obtains a referral from a GP or Specialist, schedules an appointment with a radiology group offering such services and pays a fee to have the investigative procedure done, often within 1 or 2 weeks. The wait in the publically funded system can be (but is not always) longer.

4.3 *Private Preventative Health and Wellness Groups and Executive Health Groups*

There are "wellness" related health service organizations in Alberta which, in exchange for an annual fee and sometimes an additional service fee, entitle "members" to a range of health-related consultations and not-medically-required services. Some programs offer "round the clock" or "24/7" access to a GP.

4.4 *Private Medical and Surgical Clinics in Canada*

As noted in Professor Lahey's report, the *Canada Health Act* is open to interpretation by each of the provinces and territories. The result is that

[28] Or by dentists providing publically insured surgical-dental services.

there are some differences in the scope of insured services across Canada.

Based on an internet search for *"private medical clinics in Canada"* it appears that Alberta's private clinics do not offer as extensive a range of user-pay surgical interventions as the private clinics in some other provinces, particularly British Columbia and Ontario. Albertans may therefore be able to pay for some insured surgical services in other Canadian provinces that they cannot purchase in Alberta. For example, some private surgical facilities in other provinces offer knee, elbow, hand and shoulder arthroscopy surgeries on a user-pay basis, whereas private medical clinics in Alberta do not appear to offer these services.

4.5 *Private Hospitals and Medical/Surgical Clinics in Other Countries*

Any Albertan with the will and financial means can travel to the United States or another country to buy whatever medical or surgical services they may need. There are a number of companies now offering private catastrophic health insurance which covers U.S. treatment for Canadians who suffer certain illnesses. There are also companies offering medical tourism options.

In Alberta, a physician or dentist may make an application to the Out-of-Country Health Services Committee on behalf of an Albertan for funding to cover costs of treatment which may not be available in Canada. If the application is not successful, the patient must personally pay costs if he or she wishes to access the services.

5. How Physicians are Paid and Who They Work For

Most doctors practicing in Alberta practice medicine either in individual or group practices of varying size and make-up.

5.1 *Fee for Service*

Most doctors are paid on a fee-for-service basis paid directly from Alberta Health through the Alberta Health Care Insurance Plan.[29]

The medical fee-for-service schedule is negotiated by Alberta Health and the Alberta Medical Association.

[29] *Appendix S, Practicing Medicine in Alberta, October 2012, Page 5.*

Most physicians in Alberta establish themselves as private, incorporated businesses of some form. Physicians are normally independent contractors rather than employees, except for those physicians who are full or part time employees of the government, Alberta Health Services or any other company from which they receive a salary in their personal names.

In addition to fee-for-service, physicians in Alberta may also be eligible to receive additional compensation through a number of other payment arrangements which are set out below.

5.2 *Alternate Relationship Plans ("ARPs")*

The aim of the ARP program is to develop compensation strategies – other than fee-for-service – to remunerate physicians for providing defined program services. There are 3 types of ARPs:

- academic (compensation for teaching and research in addition to clinical responsibilities);
- clinical (compensation for clinical service based on annual, sessional or capitation models, each of which have different funding models); and
- contractual (compensation for defined responsibilities).[30]

Compensation for physicians working in some on-call specialty rosters and/or as hospitalists (in-hospital paid physicians) may also fit into this category.

5.3 *Primary Care Networks and Family Care Clinics*

Primary Care Networks ("PCN's) are networks of doctors that create multi-disciplinary care teams. Originating in 2003, Alberta now has 40 networks with almost 2,500 doctors and about 600 full-time-equivalent professionals in other disciplines. In a PCN, a team of health professionals led by family doctors delivers and co-ordinates health services, with the objective of better collaboration, more timely referrals and more comprehensive care.

A PCN can be one clinic with many family doctors and other health professionals (i.e. nurse practitioners, dieticians, pharmacists, social

[30] *Appendix U, Alternate Relationship Plans.*

workers and mental health workers) or many family doctors and other health professionals in several clinics in the area.[31] Some physicians may receive sessional fees as a part of their compensation.[32]

Family Care Clinics, a new approach introduced in early 2012, provide direct access to a variety of health professionals on a team, and to other community and support services.[33] Again, some physicians may receive sessional fees as a part of their compensation.

5.4 *Physician Workforce Service Subsidies*

Where it is determined by AHS that physicians in a specific specialty or subspecialty are required to deliver a service but are not able to earn adequate compensation due to factors such as volume or time required per patient, AHS may pay a physician a subsidy in addition to what the physician is able to bill on a fee-for-service basis.

5.5 *Salary*

A small percentage of physicians are paid a salary (and benefits) by AHS, Covenant Health or the government for their administrative and/or clinical services. Examples of physicians who may be on part or full time salary include medical administration, public health, public sector laboratory pathologists, clinical associates, cancer specialists and geriatricians.

5.6 *Other Public and Private Payors/Payers*

Examples of physicians who may receive remuneration from sources other than government (fee-for-service) or AHS could include payments from groups who are defined in legislation as eligible to pay for insured services. Examples include: workers' compensation and the Canadian Forces. In addition, physicians are paid directly by a patient or their insurer for uninsured health services or by exempt groups such as automobile insurance companies.

[31] *Appendix V, AHS, What is a Primary Care Network, 2010.*

[32] Sessional fees refers to paying physicians for "sessions" of work related to specific tasks. These fees are usually based on an hourly rate. For example, psychiatrists, where considerable time is spent in team consultation or in direct patient consultation where the amount of time required with the patient may be very disproportionate to the fee paid on a fee-for-service basis. Another example is emergency physicians – many emergency departments now offer physicians a guaranteed sessional fee for working as the doctor on duty, regardless of the number of patients seen.

[33] *Appendix Q, What is primary health care?*

5.7 *Clinical Privileges in AHS*

Physicians who wish to care for patients within AHS must apply for and receive an AHS and, where required, Covenant Health Medical Staff Appointment, and approval for specified clinical privileges.

Clinical privileges within AHS are defined in the Alberta Health Services Medical Staff Bylaws as:

> The delineation of the Procedures that may be performed by a Practitioner; the sites of Clinical Activity in which a Practitioner may perform Procedures or provide care to Patients; and the AHS Programs and Professional Services that are available to a Practitioner in order to provide care to Patients.[34]

6. AHS Medical Staff Bylaws

The AHS Medical Staff Bylaws and the Medical Staff Rules govern the Physicians, Dentists, Oral and Maxillofacial Surgeons and Podiatrists who provide medical care to Patients and the Scientist Leaders who provide medical administrative leadership, in relation to an AHS Medical Staff Appointment. They establish and describe, in addition to other terms:

> …the responsibilities of the Medical Staff and AHS to each other for the organization and conduct of the Medical Staff, and in particular the processes relating to Medical Staff Appointments and delineation of Clinical Privileges.[35]

The Bylaws contain general statements about responsibilities and accountabilities such as: "The medical staff and AHS share joint responsibility and accountability for the provision of health services in a patient-centered system."[36] In addition the Bylaws state:

> Practitioners shall be governed by the AHS values of respect, accountability, transparency and engagement, AHS policies and by the AHS Code of Conduct. Practitioners shall also be

[34] *Appendix W, Alberta Health Services Medical Staff Bylaws, Effective February 28, 2011, Page 4.*
[35] *Ibid., Page 10.*
[36] *Ibid., Section 4.0.1, Page 37.*

governed by the relevant Professional Code of Conduct, and the respective code of ethics of the relevant profession.[37]

7. Covenant Health Medical Staff Bylaws

Covenant Health maintains a parallel set of Medical Staff Bylaws which are integrated with and aligned to the AHS Medical Bylaws.

8. Tracking Wait Times in Alberta

AHS is tracking, benchmarking and reporting the wait times for a number of programs and services. A summary of these reports is published in the Alberta Health Services Health Plan and Business

Plan, 2012-2015.[38] Examples of some of the wait times that are benchmarked by AHS include:

- Cardiac Surgery
- Hip Replacement Surgery
- Knee Replacement Surgery
- Cataract Surgery
- Cancer Treatment
- Emergency Department Length of Stay
- Children's Mental Health
- Wait in Community for Continuing Care Placement
- Wait in Acute/Sub-Acute Care for Continuing Care Placement.

The new Alberta Wait Time Reporting System was launched on the (then) Alberta Health and Wellness website in May 2011. The website shows wait time information on surgical procedures and diagnostic tests, including MRI scans and cancer services as reported by Alberta specialists and facilities. The site allows Albertans to search wait times

[37] *Ibid., Section 4.0.6, Page 37.*
[38] *Appendix X, "Improve Access and Reduce Wait Times", Alberta Health Services Health Plan and Business Plan 2012-2015, Section 3.1, Pages 25-31.*

by procedure, by specialist and by facility, and indicates wait times trends over the most recent 13-month period.[39]

Alberta Health also publically reports the benchmarked wait times for hip replacement, knee replacement and cataract surgery, plus wait times for continuing care.[40]

9. Federal Government, AHS and Covenant Health Policy on Preferential Access to Health Care in Alberta

Health Canada is required to publish an annual report for each fiscal year on the extent to which provincial and territorial health care insurance plans have satisfied the criteria and the condition for payment under the *Canada Health Act*.[41] Similarly, Alberta Health also publishes an annual report which contains the Minister's accountability statement, the audited consolidated financial statements of the ministry and a comparison of actual performance results to desired results set out in the ministry business plan.

9.1 *Alberta Health Services Policy Regarding Preferential Access*

The AHS website appears to contain two items related to preferential access to health care:

1. A June 11, 2009 memorandum to the AHS executive team signed by then CEO Dr. Stephen Duckett on the issue of preferential access ("the Duckett Memo") directed that any requests for Preferential or Expedited Care be referred to Dr. Duckett;[42] and
2. The policy statement that was attached to the Duckett Memo and that is currently posted on the AHS website[43] ("the AHS Policy"). This document was prepared by Dr. D. W. Megran (Senior Physician Executive) on May 10, 2009.

The AHS Policy states that:

[39] *Appendix Y, Health and Wellness Annual Report 2011-2012, Page 21.*
[40] *Appendix Z, Health and Wellness Annual Report 2011-2012, Pages 10, 11.*
[41] Health Canada Website.
[42] *Appendix AA, the Duckett Memo, June 11, 2009.*
[43] *Appendix BB, AHS Policy – Requests for Preferential or Expedited Care.*

> Providing preferential and/or expedited care based on societal status or personal relationship to health care executive or officials, rather than on medical indications and accepted prioritization pathways for care, creates conflict-of-interest for the organization and an ethical dilemma or the health care executive or official receiving a request to do so.
>
> By its very nature, such a scenario: represents "queue-jumping," a practice that a public health care organization cannot defend or support; delays or otherwise adversely affects the care of other persons awaiting or requiring care, especially when the organization has limited and inadequate capacity or resources; implies that not all individuals in society are considered "equal," or are entitled to equal treatment; suggests that the organization's current norms of care do not meet acceptable standards; exposes the organization to negative public and/or media opinion.

The policy also provides an AHS definition of preferential access, as follows:

> Preferential or expedited care includes, but is not limited to care that is:
>
> - rendered more quickly than medically indicated or required
> - rendered more quickly than the current norm of the organization
> - of a higher quality and/or is more extensive/ "thorough" than the currently provided norm of the organization
> - offered at a lower cost than is the current norm (i.e. for services or equipment that are non-insured or must be purchased by the patient).

The author understands that AHS currently has a more comprehensive policy on preferential access under development.

9.2 *Covenant Health Policy Regarding Preferential Access*

Covenant Health has developed and implemented its own policies addressing special requests for care and access to care, including patient requests for a specific provider. The Covenant Health policy[44] gives direction to staff asked to accommodate a special request stating:

> It is the responsibility of staff who have been asked to accommodate a special request to respond to the requester, investigate whether the possibility exists to meet the request without compromising clinical judgment or personal/professional reputation, and to clearly communicate and document the rationale for the decision. It is not acceptable to ignore the request, nor is it expected that every request must be, or should be, honoured. In all cases, a prudential judgment must be made in keeping with the mission, values and ethical principles of Covenant Health.
>
> Accommodating a special request that may result in another patient/resident being medically disadvantaged and seriously harmed is prohibited.

The Covenant Health policy goes on to state:

> …it is unethical and wrong to allocate resources to an individual of influence or celebrity status when someone else may be disadvantaged or harmed.

10. College of Physicians and Surgeons of Alberta: Policy

The College of Physicians and Surgeons of Alberta ("CPSA") regulates the practice of medicine in Alberta. As a professional body governed by the *Alberta Health Professions Act*, CPSA, among other responsibilities, guides professional conduct and ethical behavior of physicians.[45]

Physician behavior in Alberta is governed through CPSA Standards of Practice and the Code of Ethics and requires a high standard of

[44] *Appendix* FF, Covenant Health Policy, Accommodating Special Requests, Policy No. VII-B-5, December 1, 2010.
[45] *Appendix CC - CPSA website, Introduction to the College, Lines of Business.*

compliance to each, in order to maintain a licence to practice medicine in Alberta.

Within the Standards of Practice, the most relevant section relating to preferential access to the health system is Standard 6, *The Referral Consultation Process*, [46] which provides various standards that physicians are expected to abide by when they are considering referring a patient to a specialist for treatment. While these standards are requirements for physician-to-patient and GP-to-Specialist communication, the CPSA does not have a specific reference in its Standards of Practice related to preferential access to health services.

11. Access to Health Services is a Top Priority

The *Canada Health Act Annual Report for 2010-2011* states that the most prominent concerns with respect to compliance under the *Canada Health Act* remained patient charges and queue jumping for medically necessary health services at private clinics.[47] A similar level of concern was voiced in a 2010 Health Quality Council of Alberta survey of Albertans which concluded: "From the public's perspective access – the ease of obtaining health care services – continues to be the most important factor associated with their overall satisfaction with health care services received."[48]

12. Summary

It is hoped that this summary will provide general context for the Inquiry as it examines the subject of proper or improper preferential access to health care in Alberta.

[46] *Appendix O,* CPSA Standard 6, The Referral Consultation Process.

[47] *Appendix DD, Canada Health Act Annual Report, 2010–2011, Page 2.*

[48] *Appendix EE, HQCA Satisfaction and Experience with Health Care Services: A survey of Albertans 2010, Page 3.*

2. Research Panel Papers

(a) Submission: Contextual Ethical Analysis

Dr. Lynette Reid

Summary

Canada's healthcare system constitutes a significant expenditure of public resources in pursuit of a crucial public good – a shared standard of healthcare for all – with little accountability for performance in either equity or efficiency. Our healthcare system performs so poorly on a number of measures, including access,[1] that insiders to the system often call on personal relationships to bypass the queues that other Canadians experience, by facilitating access for themselves and their families, colleagues and their families, and prominent public figures.[2] Similarly, independent insurers (workers' compensation and motor vehicle) that stand outside medicare, acutely conscious of the costs they would incur from our healthcare system's inefficiencies, pay a premium for expedited access for their patients.[3] Such queue-jumping is not inevitable: in particular, it is not common where the most scarce and/or crucial resources (such as in transplant medicine, pediatric oncology) are managed on ethically and medically appropriate criteria such that the public trust is maintained. It is possible to organize care rationally. The culture of trading favours removes one important

[1] Commonwealth Fund. *Mirror Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally*: 2010 Update [cited 2013, Feb 15]. Available from: http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2010/Jun/1400_Davis_Mirror_Mirror_on_the_wall_2010.pdf.

[2] Anecdotally reported, documented in the media Jaimet K. Top Doctor admits to queue jump. *The National Post*; 2007, 2 December [cited 2013, Feb 15]. Available from: http://www.nationalpost.com/news/story.html?id=141706, and documented by research in: Alter DA, Basinski AS, Naylor CD. A survey of provider experiences and perceptions of preferential access to cardiovascular care in Ontario, Canada. Ann Intern Med 1998, Oct 1;129(7):567-72.

[3] Davidson A. Under the radar: Stealth development of two-tier healthcare in Canada. *Health Policy* 2006, Jul;2(1):25-33; 1; Gildiner A. The organization of decision-making and the dynamics of policy drift: A Canadian health sector example. *Social Policy & Administration* 2007;41(5):505-24; Gildiner A. Measuring shrinkage in the welfare state: Forms of privatization in a Canadian health-care sector. *Canadian Journal of Political Science* 2006;39(01):53-75; Hurley J, Pasic D, Lavis JN, Culyer AJ, Mustard C, Gnam W. Parallel payers and preferred access: How Canada's workers' compensation boards expedite care for injured and ill workers. *Health Pap* 2008;8(3):6-14.

incentive for insiders to do so: they can simply bypass the deficiencies of the system that the Canadian public must endure. Furthermore, entrenched interests and the organizational challenges posed by physician autonomy – which extends far beyond autonomy in clinical decision-making to autonomy in the management of public resources through private practice – keep us from achieving the goals of the *Canada Health Act*.

Assessing what constitutes ethical resource stewardship and improper preferential access in Canadian healthcare involves navigating a complex terrain, both in terms of ethics and in terms of the organization of care. In my submission, I sketch out the relevant ethical considerations and tradeoffs, and highlight specific practice contexts worthy of further attention and analysis.

A summary of my conclusions is as follows:

Preferential access is ***differential access*** to any of a comprehensive set of medically necessary healthcare services, where that differential access is ***based on medically and/or ethically inappropriate criteria***. Preferential access may occur ***whether access is formally or informally organized***. There are other forms of inequitable differential access: "preferential" access implies the subset of inequitable access in which there is a ***conscious granting of access*** to one person rather than another with equal or greater need. Poor coordination and organization of care, broader social and structural factors, and conflicting program goals among public healthcare systems may also cause inequitable differential access. Although some kinds of differential access are not deliberate but are "side-effects" of other policy choices or structural constraints, in some cases, these are sufficiently blatant in their effects to be considered ***de facto preferential access***.

There is no common definition of preferential access: some consider preferential access to consist only in access resulting from corruption, fraud, and conflict of interest; some define the term in relation to specific violations of the accessibility principle (7(e)) of the *Canada Health Act*.[4] However, the goals of equity and efficiency (using resources – fairly – to meet medical need) are broadly shared values in healthcare, and many people and institutions acting at the micro, meso,

[4] *Canada Health Act*. R.S.C., 1985, c. C-6. [Cited 2013, Feb 15]. Available from: http://laws-lois.justice.gc.ca/eng/acts/C-6/FullText.html.

and macro levels strive to attain these goals.[5] Therefore preferential access as access that violates mechanisms adopted to promote health equity may also be identified outside the scope of the CHA.

We can distinguish "proper" considerations that may generate differential care or access to care, including medically appropriate criteria, the promotion of equity, the responsibility to take into account the individuality and cultural specificity of patients. Another appropriate consideration is that of reasonable policy tradeoffs arrived at through accountable, transparent, and/or democratic processes, given that the pursuit of equity as an absolute value could conceivably consume unlimited resources and render society incapable of meeting other needs (education, etc.).[6] Examples of "proper" differential access include ethical processes of resource allocation, ethical advocacy, patient-centred and culturally competent care and some instances of differential access resulting from policy tradeoffs expressed in the boundaries of universal coverage (extended and excluded services or excluded persons in the CHA).

"Improper" preferential access occurs where corruption, bribery, influence trading, conflict of interest, extra-billing or similar practices, and in-group privilege lead to differential and inequitable access to publicly funded care. Furthermore, "improper" preferential access can occur as the inadvertent but foreseeable results of policy choices, as well as what might be described as a dereliction of duties on the part of those who control access to public resources: duties of performance and accountability to the funders and beneficiaries of public healthcare (the Canadian public). Examples commonly believed to fit the description of "improper preferential access" include queue-jumping, gaming the system, and extra-billing; examples that I believe also fit this description include "professional courtesy" and other forms of preferential access for healthcare insiders and public figures, the "second tier" that has arisen in care funded by workers' compensation boards (WCBs), and the ongoing absence of appropriate accountability on the part of the medical profession for the control physicians exercise

[5] See for example Whitehead M, Dahlgren G. Concepts and principles for tackling social inequities in health [Internet]. Copenhagen: World Health Organization Regional Office for Europe; 2006 [cited 2013, Jan 2]. Available from: http://www.euro.who.int/__data/assets/pdf_file/0010/74737/E89383.pdf.

[6] Norheim OF, Asada Y. The ideal of equal health revisited: Definitions and measures of inequity in health should be better integrated with theories of distributive justice. *Int J Equity Health* 2009;8:40.

over substantial expenditures from the public purse. In each of these cases, specific factors have led to *de facto* preferential access: the "historical accommodation" of Canadian medicare that protects physician autonomy at great cost to the taxpayer and patient; personal and group loyalty in a widespread (but not universal) culture of insider privilege; policy decisions that count the social costs of injury to some citizens (WCB-insured workers) while ignoring the social cost of injury and disability of others (the self-employed, informal caregivers, students, the retired, etc.), and that are inconsistent with policy decisions taken in other practice areas to enforce the prohibition on extra-billing.

What is "preferential access" to health care?

I will define and discuss "preferential access" with reference to a number of ethical principles, including principally that of equity in health and healthcare. (See Table 1 for overview of key relevant ethical concepts.)

I take the *Canada Health Act* as a defining framework for public healthcare in Canada. Although the CHA does not use the term "equity," the principles of universal (§7(b)) access to a comprehensive set of medically necessary physician and hospital-based services (§7(c)) without financial or other barriers (§7(e)) is understood to be addressing the goal of equity in access.

Table 1

Key Ethical Concepts:	
Health Equity	Three commonly given definitions: Equal access for all to the opportunity for the best achievable health; access to healthcare based on medical need alone; absence of systematic and avoidable health disparities between groups. May be in relation to access, utilization, quality, or outcomes.
Integrity	Behaviour (individual or institutional) consistent with accepted principles.
Other social values that may guide or place limits on pursuit of health equity:	
Loyalty and Solidarity	Specific responsibilities to individuals or groups based on roles and relationships.
Liberty	An equal right to individual liberty consistent with equal liberty for all places limits on means for achieving common goals, and imposes obligations to foster the conditions of liberty for all.
Other needs or desires for welfare/flourishing	Achieving health equity may interfere with our ability to achieve other social priorities, such as education, economic development, the arts, etc.
Social Justice	Goals of social inclusion in relation to the marginalized or restitution in relation to colonial history may inform the judgment of fairness in distribution or provide a rationale for differential care.

Health equity, a form of **distributive justice**, is not the only value at stake in preferential access. Other values support health equity, or shape how we go about the goal of health equity. Norms of **integrity** (in relation to resisting corruption and conflict of interest) are relevant, as are norms of **loyalty**, such as personal loyalty (to friends, family), loyalty (fiduciary duty) to individual patients or to a group of patients, professional or institutional solidarity, and social solidarity.[7] Conflicts between personal loyalty and broader social fairness exist wherever there are processes meant to apply equally to all; some dilemmas relating to preferential access take this form. **Other social values or needs**, including values relating to **individual liberty**, may limit the lengths to which we go in order actually to achieve health equity. For example, healthcare in Canada is comparatively expensive but performs comparatively poorly on many measures.[8] The extent to which we should focus on addressing our poor performance on equity rather than our poor performance on access, quality, or other measures is an important question for priority setting.

Margaret Whitehead famously defined health inequity in the following terms:

> The term 'inequity' has a moral and ethical dimension. It refers to differences which are unnecessary and avoidable but, in addition, are also considered unfair and unjust.[9]

Whitehead contends that what is considered unfair and unjust is a matter of discussion within a particular social context.[10] Equity may be considered in relation to ***access, utilization,*** or ***quality*** of care, and it may focus on opportunity or on ***outcomes***.

[7] See extensive history of the value of social solidarity in the distribution of "de-commodified goods" in the welfare state: Stjernø S. *Solidarity in Europe: The history of an idea*. Cambridge: Cambridge University Press; 2009.
[8] Commonwealth Fund, op. cit. note 1.
[9] Whitehead M. The concepts and principles of equity and health*. Int J Health Serv* 1992;22(3):429-45. See also Anand S, Peter F, Sen A. *Public health, ethics, and equity*. Oxford; New York: Oxford University Press; 2004 for a selection of recent discussions of the philosophical grounding and application of health equity.
[10] While granting that what is considered fair and unfair will differ from time to time and place to place, Whitehead contends that health behaviours that are freely chosen, and genetic or other causes of disease that cannot be altered, do not in themselves result in health inequities.

It is important to note that, despite admitted indeterminacies in the concept of equity[11] and the reality of competing values, the goal of health equity is broadly shared internationally, across healthcare systems with different mixes of public and private pay and delivery; similarly, at the national level, equity and its supporting values guide various actors in healthcare, not just the scope of the CHA.

With these values in mind, I will now define preferential access ("queue-jumping") in two contexts – where formal queues exist and where queues do not exist – and distinguish and identify inequities in access without queue-jumping.

Queue-jumping – where queues exist

Where a health resource is a public good, and it is limited or scarce, and the consequences of access for morbidity and mortality are significant, we typically guide its distribution through organized and transparent processes of resource allocation. An example is allocation of solid organs for transplantation. The resource is publicly funded and provided on a volunteer and "gift" basis by the public; the need of a patient awaiting transplant is substantial and consequences of not receiving the resource are significant. All transplant services operate under formal allocation processes guided by explicit principles. The details of the particular allocation rules we adopt and how strongly we weight each in decision-making is a local discussion, as Whitehead suggested in her definition, and may vary from province to province or from program to program. An overview of candidate principles is contained in Persad et al.[12] and summarized here (with adaptations) in Table 2. Despite local variations in criteria chosen, the commitment to equity in such circumstances is broadly shared, and accountability is strong.

With varying degrees of commitment, effort, and success, Canadian healthcare providers in other areas of practice have organized systems

[11] As seen in Table 1, equity may be defined primarily in terms of an aspiration for the best achievable health for all (based on the Universal Declaration of Human Rights), access based on medical need alone (Delamothe T. Universality, equity, and quality of care. BMJ 2008, Jun 7;336(7656):1278-81), or in terms of comparisons between socially advantaged and disadvantaged groups (Marmot MG. Policy making with health equity at its heart. *JAMA* 2012, May 16;307(19):2033-4).

[12] Persad G, Wertheimer A, Emanuel EJ. Principles for allocation of scarce medical interventions. *Lancet* 2009, Jan 31;373(9661):423-31. My table differs slightly in its analysis.

for triage and allocation for scarce or limited resources in healthcare.[13] Where there are explicit processes of resource allocation, these typically involve wait times for patients. Where there are queues, there are cases where people seek to bypass these fair systems, whether for themselves, their associates, or prominent persons.[14] This may happen through outright bribery and corruption, or through exploiting personal influence.

Where fair wait lists exist, "preferential access" is access based on personal resources or influence rather than on medical need, as judged according to agreed-upon processes of resource allocation.

There are first-order and second-order reasons for taking action against the manipulation of fair wait lists: to promote the values of equity that they embody, and to preserve the integrity of the system, that is, to ***prevent corruption and control the effects of conflict of interest*** on the part of those with insider access or the ability to influence these fair processes. This, in turn, helps secure public trust.

Survey data indicating that half of Canadians state they would call on associates to jump queues if they could[15] is often presented as indication that Canadians are not deeply committed to equity or fair access, despite 95% verbally affirming such a commitment. The data could also simply suggest that the normal ethical tension between self-interest or personal loyalty and (impersonal) fair processes exists in healthcare as in all areas of human moral life. Faced with dilemmas between fairness and loyalty, we may choose personally or socially to abandon fairness in favour of a free-for-all of personal advantage-seeking, or we may reinforce fairness with personal consequences for its violation, to better align self-interest/loyalty with fairness. Such choices are extensively explored in game-theoretic analyses of social ethics, and, of course, they form one substantial basis of our legal

[13] For instance, an extensive literature documents the organization of access to cardiac surgery in Canadian centres, e.g. Ray AA, Buth KJ, Sullivan JA, Johnstone DE, Hirsch GM. Waiting for cardiac surgery: Results of a risk-stratified queuing process. *Circulation* 2001, Sep 18;104(90001):I-92-I-98.

[14] I will use the term "associates" throughout as shorthand for friends, family, colleagues, and iterations of those relationships (family of colleagues, for example).

[15] Friedman SM, Schofield L, Tirkos S. Do as I say, not as I do: A survey of public impressions of queue-jumping and preferential access. *European Journal of Emergency Medicine* 2007;14(5):260-4.

system. The fact that people would break a rule if they could get away with it does not in itself vitiate a rule.

Table 2 – Ethical Criteria for Resource Allocation

Equal Rights	1. Equal respect for human dignity and vulnerability.
Medical Criteria	2. Distribution based on maximizing potential medical benefit. 3. Distribution based on responsibility to alleviate suffering.
Social Criteria	4. Social justice, based on responsibilities to identify and alleviate injustices and compensate for lack of voice/power. 5. Social worth, evidence-based and tied to health, security, and/or economic needs of society. 6. Social value, status-based or tied to particular conceptions of greater or lesser human value. Ethical access to healthcare will involve balancing these different values. The last value is rarely, if ever, an ethically justifiable as a criteria for access.

Queue-jumping – without queues

For much of Canadian healthcare, there are no such processes of fair and transparent resource allocation.[16] In these less organized areas, across all of medically necessary hospital and physician services, the concept of preferential access also applies. Where there is no organized queue to be jumped, there may still be queue-jumping, in the sense of bypassing the "ordinary" (disorganized) means of access to care.

[16] Flood CM. *Just medicare: What's in, what's out, how we decide*. Toronto: University of Toronto Press; 2006.

The growth of extra-billing in the 70s and 80s created a situation in which those with private means could access services to which those unable to pay could not.[17] While "queuing" did not frame the issue in the 80s, in contemporary terms, extra-billing equates to payment to jump a queue. The CHA was put in place to deal with physician practices that create financial barriers to access to care – or, put another way, practices that create financial means for patients to expedite their access to care.

The political will to meet the requirements of the CHA varies from province to province, as do the legal and regulatory mechanisms employed. Provinces may ensure compliance through specific legislation,[18] and/or through legislation and regulations primarily directed at the provincial health insurer, or at hospitals and other healthcare facilities. Physicians' provincial regulatory colleges also play a part in setting and enforcing guidelines that help healthcare providers meet these standards. British Columbia, Alberta, Ontario, and Quebec are jurisdictions where we have seen the public pressuring regulators to enforce the principles of the CHA.

The identification and ethical evaluation of preferential access is less straight-forward where there are no organized and fair wait lists. Where there is no shared understanding of fair access, the line between advocacy and queue-jumping is difficult to determine: it may be that the "normal" system for securing access to care is to call in favours. Furthermore, it is one thing to ask a person to sacrifice personal loyalty (or self-interest) to fairness where there are fair processes, and more difficult to expect such a sacrifice to an unfair process in the context of inadequate access for all.[19] In a "free for all" of players seeking advantage for themselves and their associates, it may be exceedingly difficult to gauge the boundaries of ethical advocacy.

[17] More technically, the provinces must regulate the practice of medicine such that there not be "financial or other" barriers (7(e)) to a comprehensive (7(b)) and universal (7(c)) package of medically necessary hospital and physician services, on penalty of foregoing healthcare funding from the federal government.

[18] As, for example, in *Ontario's Commitment to the Future of Medicare Act, 2004*, SO2004, c5, s. 17(1) [Cited 2013, Feb 15]. Available from: http://canlii.ca/t/kv43.

[19] An example of the argument that personal loyalty may trump fair process in access to healthcare is Browne A, Browne K. Morality, prudential rationality, and cheating. *Camb Q Healthc Ethics* 2007;16(1):53-62.

Nonetheless, despite the lack of organized queues, basing access to any part of a comprehensive package of medically necessary hospital and physician services on ability to pay is prohibited under the *Canada Health Act*,[20] and so we identify extra billing and equivalent practices as forms of preferential access. Although this is not preferential access in the sense of bribery, corruption, or conflict of interest on the part of the provider, it is preferential access in relation to the broad policy goal of ***ensuring universality and accessibility*** of public healthcare in Canada, and it is legally proscribed for services and persons covered by the CHA. It is important to note that there are services not covered by the CHA that are similarly governed by norms of equity (e.g. Public Health programs), such that forms of preferential access may similarly be identified in areas not covered by the CHA.

Table 3 – "Public Healthcare" in Canada

Publicly funded but not within the scope of the CHA; may purchase services from public system or from persons or institutions who also provide services in the public system: • Public Health (health protection, promotion, and prevention services, typically delivered outside of hospitals and often not by physicians) • Federal programs that are substitutive or that fund extended benefits for particular populations (First Nations and Inuit Health; (formerly, refugee health, RCMP); Armed Forces; Inmates) • Provincial pharmacare, home care, longterm care programs; may be universal or needs-tested • Provincial motor vehicle insurance (MVI), in some provinces
Privately funded but operating under a public mandate; may purchase services from the public system or from persons who also provide services to the public system: • Private MVI in some provinces • Provincial workers' compensation (WCB)

[20] Leaving aside opted out physicians and the provisions for and controls on them (and on insurance) that vary across the provinces. Flood CM, Archibald T. The illegality of private health care in Canada. *CMAJ* 2001, Mar 20;164(6):825-30.

Table 4

Key Definition and Related Concepts

- **Preferential access** is ***differential access*** to any of a comprehensive set of medically necessary healthcare services, where that differential access is ***based on medically and/or ethically inappropriate criteria.***
- Access based on criteria that are medically and/or ethically inappropriate is ***one form of inequitable differential access*** (the application of medically appropriate criteria is necessary but not sufficient for equity in access; there is differential and inequitable access that is not "preferential").
- "Preferential" access implies a ***conscious granting of access*** to one person over another. Other mechanisms (poor coordination and organization of care, structural factors, conflicting program goals within public healthcare) may also cause inequitable differential access.
- Preferential access may occur ***whether access is formally or informally organized.***
- Some instances of inequitable differential access that result from structural features of Canadian healthcare, while they are "side-effects" of other policy choices and not deliberate acts of preference for one patient over another, are sufficiently blatant and similar in their effects to be considered ***de-facto preferential access.***

Inequities with neither queues nor queue-jumping

There are many kinds of inequities in access, utilization, and quality that would not be described as "preferential access" because they result from structural factors or from acts of omission rather than commission. They may be unintended consequences of the organization of a service or location: a hospital is built closer to some people than others, creating inequalities in access to emergency care; such unintended inequalities may even reach the threshold of being inequities, if the inequality is unfair and remediable.

It may be that, in Canada, problems of access for everyone and problems of inadvertent or structural inequities both outstrip in their impact the problem of preferential access, where that is understood as deliberate actions to grant access to one person over another with equal or greater need.

Is there a common definition?

No, there is not a common definition. Different candidate definitions may focus on the goal of ***controlling corruption*** in business and public affairs, or on the principles of the *Canada Health Act* and its mechanisms, or more broadly on the shared ethical commitment of the profession and of health systems to ***health equity***, which may apply to services publicly or privately funded, or publicly or privately provided, inside or outside of the medicare basket.

Preferential access to public healthcare may include, be related to, or be distinguished from the following (see Table 5 for summary):

1. Differential and deliberately expedited access based on **corruption**: bribery, influence peddling, and rent-seeking;
2. Differential and deliberately expedited access based on **conflict of interest and status, influence, and unspoken expectations** that insiders to the system, their associates, and public personalities enjoy special treatment;
3. Differential and deliberately expedited access based on "**professional courtesy**" or other forms of special consideration for insiders to the system or their close associates;
4. Differential and equitable access or treatment based an **ethically-appropriate advocacy**;
5. Differential treatment based on **culturally competent patient-centred care**;
6. Physician billing practices that are or are equivalent in their effects to **extra-billing**, insofar as this may or may not be successfully controlled by provincial governments and regulators, in light of their responsibilities to meet the requirements of the *Canada Health Act*;

7. Differential access that arises **from individual and arbitrary management of wait lists** for essential services without transparent criteria and processes;
8. Differential access based in **ethical processes of resource allocation and wait list management**;
9. Differential and sometimes expedited access to services to **"extended" and excluded healthcare services**[21] under the CHA, whether these services are publicly or privately funded, and whether the provinces intend or do not intend to deliver these services under the principles of universality and accessibility;
10. Differential and sometimes expedited access based on **differential status** of persons under the CHA,[22] given its exclusions and the responsibilities of other public and private payers for their care;
11. Differential and sometimes expedited access based on an **absence of transparent, accountable resource allocation processes** throughout Canadian healthcare;
12. Differential access based on **broad structural issues**: geography, language and literacy, social determinants of health, and so on.

Is there a difference between "proper preferential access" and "improper preferential access"?

The choice is a semantic one, between reserving "preferential access" for preferential access that instantiates corruption and/or threatens health equity, or using "preferential access" for both equitable access delivered with integrity and corrupt/inequitable differential access, while qualifying the latter with "improper."

[21] Extended services are nursing home care, adult residential care, home care, and ambulatory care. Excluded services are any healthcare services and products delivered by healthcare professionals other than physicians outside of the hospital setting, e.g. physiotherapy, and other care by healthcare professionals, pharmaceuticals in the community. The category of excluded services also includes non-medically necessary hospital- and physician-delivered care: cosmetic surgery, laser eye surgery, assisted reproduction, etc.

[22] I.e. care for those covered by workers' compensation, for inmates, for members of the Armed Forces, and for those who do not yet meet the residency requirements in a Canadian province.

I prefer the first option for its ethical clarity: we should think in terms of a goal of access based on medical and ethical criteria, delivered with integrity, and reserve "preferential access" for access that in some way violates the principles of equity and integrity. If equitable access based on medical need is labeled "preferential access," then it would be "proper preferential access." This is not, however, useful language: on these terms, all healthcare should be delivered "preferentially," insofar as it should always be delivered in accordance with people's differing kinds and levels of medical needs.

Table 5

Forms of Differential and Preferential Access:

1. Corruption (bribery, influence peddling, and rent-seeking).
2. Status, influence, conflict of interest.
3. "Professional courtesy".
4. Ethical advocacy.
5. Culturally competent patient-centred care.
6. Extra-billing and similar practices.
7. Arbitrary variation in management of wait lists.
8. Ethical processes of resource allocation and wait list management.
9. "Extended" healthcare services under the CHA.
10. Differential status of persons under CHA.
11. Absence of transparent and accountable resource allocation.
12. Structural issues.

In your opinion, what would be examples of "proper" preferential access to health care?

I would consider some items in Table 5 list to be "proper" differential or expedited access, specifically:

4. Ethical advocacy;

5. Culturally competent patient-centred care;
8. Differential access based in ethical processes of resource allocation and wait list management;
9. Some instances and aspects of differential access to extended and excluded healthcare services;
10. Some instances and aspects of differential access based on differential status of persons under the CHA.

What renders these "proper" is that they incorporate medically appropriate criteria (4, 8, 9), promote equity (4, 5, 8), take into account the individuality and cultural specificity of patients (4, 5), and/or represent reasonable tradeoffs arrived at through accountable (8), transparent, and/or democratic processes (9, 10).

Is there harm to the public health care system associated with "proper" preferential access to health care? In your opinion, what is the nature of that harm? Is that harm acceptable from an ethical or practical perspective?

In answering these questions, I will focus on harms and ethical trade-offs in general, and on items in my list that are not addressed in separate questions by the Inquiry below.

Ethical processes of **resource allocation and wait list management** (8) involve making difficult choices in which different possible values for prioritizing access to care must be weighed (e.g. medical need, medical benefit, alleviation of suffering, social vulnerability, social value, equal regard for human dignity, etc.; see Table 2). Such ethical processes ***enhance the efficiency and equity*** of the system, enabling us to dedicate resources to areas of greatest need or greatest potential benefit. They also contribute to making the system ***worthy of public trust***, insofar as the criteria they employ are fair. They may even ***enhance trust*** particularly when adoption and application of the criteria involve transparent and inclusive processes.

Each particular principle for prioritizing access has its own potential for harm: ethical choices involve tradeoffs in which competing values may be modified or threatened.[23] In specific instances, conscious resource

[23] Persad et al., op. cit., note 12, summarizes the downside of each possible allocation rule.

allocation and wait list management itself may involve ***resources that are disproportionate to the benefits to equity or efficiency gained*** by any access system more elaborate than "first come, first served." Such systems may ***incur opportunity costs***. For example, while triage based on urgency at an Emergency Department is universal, triage at the point of access to primary care is not commonly performed: any patient calling for an appointment receives the next available appointment that suits their schedule, with informal flexibility for urgency. Furthermore, fair processes run the ***risk of inflexibility*** where more flexible processes, including a scope for the exercise of professional autonomy, might be argued to better serve the needs of patient-centred care. For example, formalizing the first-come, first-served access for primary care may degrade equity by imposing inflexibility on providers who may perhaps be trusted to appropriately exercise their professional autonomy in the service of meeting patients' needs.

These possible harms must be taken seriously in organizing systems of access. They are not reasons for rejecting wholesale formal access controls. While some may argue that "muddling through" is the best method of resource allocation for patients in light of the above concerns,[24] the majority view, which I share, is that deliberate and transparent processes of resource allocation are preferable.

I will discuss **ethical advocacy** (4) below in the specific questions from the Inquiry. Ethical advocacy is action to ensure that patients receive the care that is due to them based on their medical needs. Patients are more than their illnesses: their individual values and context, including culturally influenced beliefs and practices, enter into and must be taken into account in the healthcare encounter. **Culturally competent patient-centred care** (5) is similar to ethical advocacy in that it involves action by healthcare providers and systems to attend to individual patients' needs, defined by the individual's unique perspective on the world and the cultural influences that may shape that perspective.[25] Such differences do not typically equate to differences in

[24] Mechanic D. Muddling through elegantly: Finding the proper balance in rationing. *Health Aff (Millwood)* 1997, Sep 1;16(5):83-92.

[25] Examples of the considerations relevant to healthcare delivery that may be culturally influenced include rituals relating to birth and death, dietary restrictions, treatment restrictions and preferences, and appropriate involvement of family in decision-making. A family meeting with 20 present to support the patient and the legal substitute decision-maker may be more time-consuming for the team than a family meeting with one substitute decision-maker, but requiring that all patients and families fit the "autonomous

access, but they may involve greater expenditure of resources to achieve the same access.

There are ethical and medical rationales for such customization in care related both to efficiencies (***removing barriers to appropriate care*** to prevent future morbidity and mortality) and values such as respect and ***social inclusion***,[26] goals broadly consistent with and supportive of ***equity***. In some cases, these values are enforced by law (e.g. bilingual services in NB) or legal precedent (sign interpretation for hard of hearing patients).

Social inclusion is an on-going public discussion, with debate centered around the goals described above and what some consider to be potential harms, such as whether the goal of social inclusion may oblige us to endorse oppressive values, whether the expense of individualization and inclusion may be in some instances unacceptably high, whether we may paradoxically foster social division by policy mechanisms aimed at inclusion.

Both ethical advocacy and culturally competent patient-centred care involve grey areas and the exercise of individual professional discretion, and are sensitive to the degree that patients and groups are able to advocate for themselves. That is, having permitted a scope for these values, they may be implemented imperfectly and may be subject to abuse or manipulation.

Differential access at the **boundaries of medicare – to services excluded** from the CHA (9) and differential access based on **status** under the CHA (10) – raise broad and complex issues. In and of themselves, they may constitute differential access without necessarily constituting or leading to preferential access.

Some of these services are nonetheless **publicly funded** (see Table 3). Some of these publicly funded or publicly mandated services, although outside the CHA, nonetheless are delivered by provinces on terms that

patient" model with a single substitute decision maker would be placing an access restriction on some Canadians and not others, i.e. a requirement that you must abandon your family's and culture's practices of familial decision-making.

[26] See Kymlicka W. *Liberalism, community, and culture*. Oxford: Oxford University Press; 1991 and Taylor C. The politics of recognition. New Contexts of Canadian Criticism 1994:98-131 for Canadian discussions (liberal and communitarian) of the grounds for social inclusion.

aspire to fulfill the spirit of the CHA or the spirit of equity. For example, provinces have acted to remove incentives to more expensive (hospital-based and physician-provided) care where other care locations and providers may be less expensive and more appropriate to patient needs. To do this, they cover home care, nursing home care, and nurse-provided care on terms and conditions equivalent to the CHA terms and conditions, or terms that are designed to promote equity but are not uniform. Another example is public health, including vaccination and health promotion activities, which is delivered historically with a strong commitment to equity and may fit some but not all principles of the CHA. Provincial pharmacare programs, similarly, may be means tested instead of universal, while still publicly funded and guided broadly by principles of equity. In all these areas, the principle of uniform terms and conditions may be sacrificed in order to target resources at areas of greatest need, and income-dependent co-payments may be tolerated. Despite their status as excluded or extended services under the CHA, there may be queue-jumping that we must attend to as closely as we attend to queue-jumping for CHA-covered services.[27]

At the boundaries of medicare, it may be unclear whether an exclusion serves a particular policy goal or is an accident of history. For example, the need for cost containment in light of other priorities for public funding dictates limits to healthcare coverage: it is generally thought that we could not cover pharmaceutical and devices in the community, longterm care, and home care on the terms of the CHA (universal access on uniform terms and conditions) at taxation levels acceptable to the electorate without encroaching unacceptably on the provinces' other funding priorities, such as education, infrastructure, and security. Furthermore, some excluded services relate to enhancement and to prevention: individual liberty argues in favour of not interfering with the rights of some to pursue these areas where there is not a broad social consensus to support all to pursue them equitably. Other more specific policy goals, such as the historic bargain of workers

[27] Longterm care in some provinces is managed on a single-wait list access (e.g. NB, NS), while in other provinces there are simply two tiers of longterm care and private payers receive officially sanctioned preferential access (e.g. PEI). Preferential access may arise from variable enforcement of facilities licensing laws (direct access, private pay non-nursing home facilities may offer expedited access to a level of care that ought to bring them under the umbrella of nursing home regulations and single-wait list access and so rule out that expedited access) or application of resident selection criteria (preferentially accepting private pay residents, a practice that would be vulnerable to complaint on human rights grounds).

compensation (trading coverage and financial accountability for employers with unsafe worksites with the workers' right to sue), or the relationship of First Nations and Inuit people with the federal government, or the separate system for coverage of prisoners, may be seen as serving particular policy goals, or as the result of convenience at the time of the founding of medicare. Medicare did not seek to provide coverage where coverage was already in place.

The need for cost containment, the historical process of policy development, the necessary limits of coverage, and the liberty of individuals to choose care beyond the universal package, where available, create forms of "proper" differential access. Those who can pay may have access to drugs, to home care and assisted living options that have a substantial impact on morbidity and mortality, while those who cannot, wait on wait lists until they deteriorate to a point where they require more substantial, covered care.

The two-tier systems in Canadian healthcare resulting from limitations in coverage of the CHA do cause known harms. They are to some extent transparent and accountable, and chosen by political processes. I would join with those who advocate that we make different policy choices as a society in some of these areas, particularly in pharmacare. Nonetheless, they do represent proper democratic policy choices.

In your opinion, what would be examples of "improper" preferential access to health care?

I would consider some items in Table 5 list to be "improper" differential or expedited access, specifically:

1. Corruption (bribery, influence peddling, and rent-seeking).
2. Status, influence, conflict of interest.
3. "Professional courtesy".
6. Extra-billing and similar practices.
7. Some instances of arbitrary variation in the management of wait lists.
9. Some instances of the interface between "extended" and covered healthcare services under the CHA.
10. Some instances of differential status of persons under CHA.

A note about the absence of transparent and accountable measures of resource allocation (11) and about structural inequities (12): While differential access that arises from the absence of good resource allocation procedures in Canada[28] and differential access based on structural issues such as social determinants of health are not "proper," these are even broader and more structural issues than the ones I identify as constituting "*de facto* preferential access."

The absence of transparent and accountable processes of resource allocation, for example, results in imbalances between funding of stigmatized and valorized conditions, so a person with schizophrenia receives substantially worse care for schizophrenia than a person with a myocardial infarction receives for myocardial infarction (rather than differential access for two patients with the same condition to the same treatment).[29] Arguably, such inequities in Canadian healthcare cause more suffering and injustice than the more local inequities in access that this submission and Inquiry are concerned with. Indeed, the global conversation is now concerned with inequity in relation to the social determinants of health[30] and inequities in relation to corruption, conflict of interest, and favour-trading are not much discussed. We are under a broad ethical obligation to address these broader inequities when we can, and there is no doubt that Canada can do better in these areas. The achievement of medicare has, arguably again, left us complacent, while the disorganization of our system has also left us relatively powerless to address these issues.

Is there harm to the public health care system associated with "improper" preferential access to health care? In your opinion, what is the nature of that harm? Is that harm acceptable from an ethical or practical perspective?

In answering these questions, I will focus on general harms and ethical tradeoffs, and on items on my list that are not addressed in separate questions below from the Inquiry.

Preferential access based on corruption (1) is improper, and its harms include ***violation of the public trust, misuse of office, and the***

[28] Flood CM. *Just Medicare: What's in, what's out, how we decide*. Toronto: University of Toronto Press; 2006.
[29] Starfield B. The hidden inequity in health care. Int *J Equity Health* 2011;10:15.
[30] Marmot MG. Policy making with health equity at its heart. *JAMA* 2012, May 16;307(19):2033-4.

diversion of resources from those in medical need to those with resources, influence, and a willingness to trade on them unethically and illegally to ensure their own needs are met. It is probably unnecessary to add that there are no arguments, apart from ethical nihilism, to the effect that these harms are acceptable. However, as with all wrong-doing, total eradication is impractical and may require excessively intrusive means, violating principles of ***liberty*** and threatening other priorities for use of resources.

I believe access expedited by **status, influence, and conflict of interest** (2) to be equally unacceptable and harmful in terms of trust, use of office, and diversion of resources; when the exchange is less blatant and material than in (1), we may enter into grey areas. Insofar as personal and professional loyalty may be positive values in some contexts, some instances of requests or pressures for preferential access based on status, influence, and conflict of interest may pose genuine dilemmas for healthcare providers juggling different roles, loyalties, and relationships.

I believe, while acknowledging it is a matter for discussion, that so-called **professional courtesy** (3) and other forms of preferential access for insiders to the system are also improper preferential access, and are not substantially different from access offered on the basis of influence or conflict of interest (2). I will discuss these below in answer to specific questions from the inquiry.

Preferential access based on **extra-billing** (6), which the CHA outlaws via the pressure it places on provinces, is improper, causing harm in the form of violation of the principles of universality and accessibility, potentially depriving individuals of medically necessary care and so contributing to suffering and death, and placing a financial burden on individuals in need of healthcare with attendant social harms of the sort that medicare was designed to prevent.

I will argue in relation to the boundaries of medicare (8) and (9) that the CHA fails to control all instances where the interface between public and private care (or among public systems) creates preferential access (potentially troubling practices summarized in Table 6).

I consider differential and *de facto* preferential access based on **individual and arbitrary management of wait lists** (7) to be improper. That is not to say that in a single instance an individual

physician should be held culpable for how they manage wait lists; lack of coordinated and conscious management of wait lists aimed at the public good is not the same thing as giving individual patients expedited access through corruption and influence peddling or through less conscious but still professionally culpable conflict of interest. The public has (apparently) accepted since the adoption of medicare that care should be delivered in such a disorganized fashion. This is a particular feature of Canada's healthcare system: Physicians enjoy considerable professional autonomy while they are, in effect, managing a public resource. This individual and arbitrary variation in management of access to services could even be considered as officially tolerated and sanctioned.

Nonetheless, access to surgery is determined by which primary care physician one happens to see, who in turn may happen to have a good referring relation with a particular surgeon, who in turn may happen to have the most claim on OR time due to seniority: this is not preferential access in the narrow sense outlined above (corruption; violation of CHA), but it is differential and inequitable access that I would argue professionals have the responsibility to foresee and address.[31] I consider it to be an on-going dereliction of a professional ethical duty and of accountability to the taxpayer and beneficiaries of the system to steward public resources in a responsible fashion. Neither the responsibilities of provinces, health districts and individual hospitals, nor the responsibilities of individual physicians and of group practices, can be ignored in crafting a solution: Canada is one of only two countries in a recent Commonwealth Fund survey where physician payment is independent of hospital budgets.[32] All relevant parties should, in my opinion, be placed under stronger legal/policy obligations, to organize care to meet medical need – for both equity and efficiency.

The disorganization of access, apart from constituting a failure in accountability to the public, also creates the context for more culpable instances of preferential access. For example, referring relationships may be with private facilities that offer CHA-covered care bundled

[31] It may be a factor in the relative challenges in achieving equity in specialist services: see Starfield, op. cit., note 29.
[32] The other is the US. See Squires et al. *International profiles of health care systems*, 2012 [Internet]. New York: The Commonwealth Fund; 2012 [cited 2013, Feb 15], p. 9. Available from: http://www.commonwealthfund.org/Publications/Fund-Reports/2012/Nov/International-Profiles-of-Health-Care-Systems-2012.aspx.

with other services, and in a context of broad professional autonomy, referring practices may include preferential booking for those referred from such facilities offered bundled services over those referred from practices focused on CHA-covered care. Another example is the way in which access in some areas may be so poorly organized that fair, equitable advocacy cannot be distinguished from "calling in favours."

Table 6

Examples of *potential or actual* spillover effects on access and equity for services outside the boundaries of medicare

- Private access to diagnostic imaging and lab services resulting in expedited access to public care;
- "Tray fees" and other practices of billing patients for services or supplies necessary for the delivery of medically necessary services;
- Private surgical facilities billing the provincial plan but requiring extended stays not funded by the provincial plan;
- Medically necessary surgery, billing the provincial plan or not billing the plan, using devices not funded by the hospital or provincial insurer;
- Chemotherapy with drugs not on the hospital or provincial formulary;
- Other methods of bundling medically necessary and extended/excluded services;
- Expedited access by premium payment for patients covered by WCB and MVI;
- Differential and preferential referring relationships, which may be with practices bundling basic and excluded services.

Services and persons not covered

At the boundaries of CHA coverage (**extended and excluded services, and excluded persons** (9-10)) there are practices that would constitute or resemble extra billing (6), and cause the similar harms, but that are

in my opinion inadequately controlled and constitute forms of preferential access.

Separate systems may be warranted by policy goals, as in the WCB system, but potential harms exist: they include that the ***separate system may offer worse access and care*** than the more broadly shared public system (a concern in prison health and in First Nations and Inuit health, even while the package of care may be larger, i.e. include extended benefits), and that the ***separate system may offer expedited access*** in relation to the public system, i.e. forms of preferential access to public healthcare that are currently tolerated or sanctioned but that I would consider "improper." Where there are separate and private systems, potential harms are that expedited access to private care should in effect expedite access to public resources, and that the close integration of public and private services should create *de facto* means of preferential access for those able to afford to access integrated services where the core services covered under CHA or other programs guided by similar values are not accessible.[33]

Some harms of the separate system may be acceptable in relation to the necessity of weighing the policy goals outlined above. In some cases, crafting regulation to prevent spillover effects (see Table 6) for access to the (CHA-governed) public system may not be possible.

In some instances, separate public or private systems exacerbate resource limitations and, in particular, health human resource limitations in the public system, degrading access to CHA services for all, but not necessarily creating preferential access (apart from, by definition, the preferential access to the non-CHA services). Certainly, wait times for diagnosis of macular degeneration or cataract surgery are affected by the amount of time a limited number of providers are spending in private practice doing procedures that are not covered as they are considered to be "enhancement" services or not to offer a favourable cost-utility balance. I know of no evidence whether public provision of privately funded chemotherapy (expensive drugs covered by private insurance but not hospital formularies) creates similar pressures on access for all. It behooves the system to attend to these affects – to incentives to health human resources to exit the public

[33] The harms and purported benefits are discussed in the collection Hurley et al, op. cit., note 3.

system – and we do so in various ways,[34] but some of these practices are unavoidable given goals of cost containment and respect for liberty.

However, such practices may constitute preferential access, and be avoidable through clear regulation, in cases such as the following:

- A CHA-covered ***procedure*** with a non-hospital or provincial insurer-funded ***drug or device*** is re-interpreted as a non-CHA-covered procedure, and providers bill privately, at a premium, and offer preferential access, when this practice is designed to circumvent a particular province's mixture of laws on direct patient billing (is it permitted and is it restricted to the same reimbursement that the province offers?) and status disincentives (may the patient claim back the portion covered by the province?).
- A non-CHA-covered procedure that addresses the same medical problem as a CHA-covered procedure is billed privately, at a premium, and patients who elect that service are offered preferential access.[35]

Some practices would be simple to regulate and others more difficult.

Bundling of covered and not-covered services

Another form of preferential access that may occur at the boundaries of medicare is where services that are medically necessary hospital-based or physician-delivered services are bundled with extended or excluded services (or bundled with services for persons not covered under the CHA), and then access to the CHA-covered care is available only to those purchasing the whole package.

[34] Canadian provinces approach the policy goal of de-incentivizing exit from the public system in local and piecemeal ways, sometimes with no legal restrictions, simply relying on the lack of a market (NL) and in other provinces with various restrictions on insurance and billing that resist the growth of this sector. (Flood & Archibald, op. cit., note 20.) This functions more or less adequately at a global level to prevent the widespread development of financial barriers to covered services, but it has permitted the growth of financial barriers to care in certain areas.

[35] In both cases, the problem of access is exacerbated by the same physician offering both services, as s/he has an intrinsic interest in steering patients towards selecting the premium service and away from the publicly funded one.

This is widely forbidden by the regulatory colleges when it takes the form of "boutique medicine," which is where a physician practice charges a kind of retainer fee to be accepted as a patient. In the case of boutique practices, the regulatory colleges have placed requirements around it to prevent financial or other barriers to access:[36] physicians must unbundle services so that patients can access CHA services independently of paying for other services; physicians must consider the ability of the patient to pay; physicians must not refuse access to patients who do not buy the extended services, and, most crucially for our purposes, ***physicians may not charge a fee for being available to provide a CHA-covered service or for providing such a service in an expedited fashion, as these practices would be considered extra-billing.***

The regulatory colleges are less clear about the acceptability of similar access barriers in other contexts, such as rehab and sports medicine (I know of no comprehensive overview of such practice models and specialty areas).

In fact, for separate (public) coverage of WCB patients, the explicit policy decision was that, ***while a given surgery may be medically necessary, a given surgery within 6 weeks may not be medically necessary, and so it may be paid at a premium to give physicians and facilities incentive to expedite that surgery.***

I agree with the regulatory colleges' interpretation that paying for expedited access to covered services is impermissible, and reject the WCB/MVI interpretation, which sets the stage for a form of ***officially sanctioned but improper preferential access*** – queue-jumping by WCB-covered patients (and, under the interpretation, other large insurers such as MVI).

In addition, contracts with the WCB and MVI companies are typically the bread and butter of clinical practices that offer bundled CHA and

[36] See, for example, College of Physicians and Surgeons of Alberta. Standard 18: Charging for uninsured services. Standards of practice. Edmonton AB: CPSA; 2010 [cited 2012, Nov 25]. Available from: http://www.cpsa.ab.ca/Libraries/Res_Standards_of_Practice/CPSA_Standards_of_Practice_Consolidated_Version.pdf; College of Physicians and Surgeons of Ontario. Block fees and uninsured services. Toronto: CPSO [cited 2012, Nov 25]. Available from: http://www.cpso.on.ca/policies/policies/default.aspx?ID=1612.

non-CHA services, and such clinics may then also offer "executive healthcare" or employee wellness packages.

Neither the CHA nor the regulatory colleges address the restrictions on access that such clinics present (a separate issue apart from referring relationships relating to these clinics as outlined above). There are at least two dimensions here. One is whether a clinic with such a business model in itself represents a violation of the CHA, and how this could be defined and regulated given that physicians may, in general, control their own practice balance of covered and non-covered services. In addition, such clinics typically perform screening that exceeds what is recommended in practice guidelines, and this has an impact on efficiency and on equity for the public system, as excessive screening leads to excessive use of resources for over-treatment and faster access for those excessively screened.

The CHA envisions eliminating financial barriers to access to care by prohibiting physicians from adding extra fees to what they bill the provincial insurer. It does not envision or adequately control for making access conditional on bundling of insured and non-insured services.[37]

In your opinion, would you characterize the following examples as “proper” or “improper” access to health care? [Explain with reasons where applicable]

Physician Advocacy? Is this a good thing? Why or why not?

Physicians have a responsibility to advocate appropriately for their patients, to ensure that they receive the services they need and to which they are entitled. This is enshrined in the CanMEDS Health Advocate

[37] I believe this issue will only grow as interprofessional team care in the community grows – a desirable development – and this moves more and more care out of the overview of the CHA. It becomes a matter for provincial government policy, facilities licensing regulations, primary care reform models, and health district planning whether the core principles of the CHA hold across new care models, which may involve the delivery of medically necessary care by pharmacists and nurse practitioners, for example, whose practice in the community is not covered by the CHA. Developments in this area are likely to be marked by the federal-provincial wrangling that too often replaces effective healthcare planning in Canada. A modernized CHA or modernized provincial policy would, in my view, make explicit the policy goals of universal access to a comprehensive set of medically necessary care on uniform terms and conditions without financial or other barriers, without the antiquated restriction to physicians and hospitals.

role,[38] in common law,[39] and in professional ethics. They have a responsibility to distinguish this from "queue-jumping" or "gaming the system."[40] One touchstone to distinguish advocacy and queue-jumping is the responsibility to advocate equally or equitably for all patients, or to focus advocacy in areas of greatest need (for the most vulnerable patients).[41]

Allowing a physician or hospital worker to obtain an MRI faster than spending time on the waiting list?

I consider this to be improper preferential access, based on insider privilege.

It may be rationalized by those who engage in the practice by the social value of physicians or hospital workers, considering "social value" as a possible principle of ethical resource allocation.

There are well-known concerns about social value as a criterion for allocation of scarce medical resources. Social value is to a large extent in the eye of the beholder. Fair judgments of social value are costly and intrusive.

There are situations where allocation based on social value is contemplated, in particular, in military triage or in public health emergencies, where the viability of the system to meet the threat creating the shortage is dependent on human resources, and these human resources are themselves at a heightened risk from the threat. Insofar as resources in question are particularly scarce and consequential in such situations, the judgment of social value must be tightly tied to the social need to meet the immediate urgent situation and the particular role of persons in meeting that need.

[38] RCPSC. The CanMEDS 2005 Physician Competency Framework: Better standards, better physicians, better care. Ottawa: Royal College of Physicians and Surgeons of Canada, 2005.

[39] Sibbald B. Is scarcity of resources a valid legal defence? CMAJ 2000, Mar 21;162(6):880.

[40] Van Rosendaal GM. Queue jumping: Social justice and the doctor-patient relationship. Can Fam Physician 2006, Dec;52(12):1525-6, 1527-8; Cunningham N, Reid L, Macswain S, Clarke JR. Ethics in radiology: Wait lists queue jumping. Can Assoc Radiol J 2012, Aug 4.

[41] A useful discussion of the balancing act in clinical practice is Menzel P. Allocation of scarce resources. In: Rhodes R, Francis LP, Silvers A, editors. The Blackwell Guide to Medical Ethics. Oxford: Blackwell Publishing; 2007.

In the kind of case envisaged by this question, it does not inspire public trust that this judgment of social value is made in the situation where the same parties control access to the resources and judge themselves to be especially socially worthy to receive them. Healthcare workers may not be the best judges of whether their role in society is more essential than those of police officers or teachers or transportation workers or home-makers providing substantial unpaid care for children, parents, and other community members.

The idea that healthcare access depends on the superhuman endurance of a single physician who never falls ill is a fading ideal. The idea that enduring a painful hip or missing work while on a wait list is worse for a physician than for other people is dubious. The idea that healthcare workers may suffer greater anxiety at the unknown does not seem evidence-based; even if it were, management of anxiety is not commonly proposed as a fair principle of resource allocation.

Such practices may be rationalized as preserving and facilitating working and referring relationships, as examples of professional solidarity and appropriate team behaviour. I believe there are ways to enhance working relationships while basing them on a shared ethical commitment to equitable access based on medical need.

I consider such practices to be examples of professional solidarity overtaking social solidarity: healthcare workers acting to privilege fellow insiders to the system over serving the public equitably. The pressure to preserve professional solidarity at the expense of patients is a troubling phenomenon posing well-known challenges for self-regulation, which ostensibly protects the public and also faces limits posted by insider solidarity.[42]

An argument in favour of healthcare providers adopting a perspective of **social (rather than professional) solidarity** is that when insiders to the system experience the consequences of how the system works, those with (relative) power and influence are appropriately motivated to remedy access and quality problems; allowing insiders to exit the

[42] A recent contribution to the literature discussing this problem is DesRoches CM, Rao SR, Fromson JA, Birnbaum RJ, Iezzoni L, Vogeli C, Campbell EG. Physicians' perceptions, preparedness for reporting, and experiences related to impaired and incompetent colleagues. *JAMA* 2010;304(2):187-93.

public queue is likely to exacerbate the problems of the public system.[43]

Hospital or medical staff obtaining flu shots before the general public?

I will distinguish a scarce vaccine for a pandemic outbreak from seasonal flu shots.

In the case of resource allocation decisions in a situation of a public health emergency, allocation would be based on medical need/prevention of harm. In a given outbreak, it may be appropriate for those who experience exposure to a given risk while providing essential services related to managing that risk to receive preferential access. This would be an instance of ***ethically appropriate resource allocation*** based on evidence-based social value.

Some argue that a principle of ***reciprocity*** for service should also be in play. I am not in favour of mixing reciprocity and medical need: there are ways of expressing public appreciation that do not interfere with the distribution of healthcare based on medical need. This is an area of active debate and discussion.

Where scarce resources are allocated on the basis of social need (or society's medical needs), a careful, transparent, and multi-dimensional assessment should be made to ensure that a fair judgment is made about who is at risk (e.g. are teachers or transit workers also highly exposed?) and who is essential (e.g. are hospital housekeeping staff also essential workers?), and who is not (e.g. is an administrator who works offsite during an outbreak especially at risk?).

Outside of the pandemic context, seasonal flu vaccines are not typically in short supply, and they may be delivered by physician services and/or by public health and/or employer-based programs. That is, these are services delivered at the ***boundaries of medicare,*** within and/or outside of the CHA, with its specific conditions of universal access on uniform terms and conditions without financial and other barriers. Within a context of sufficient supply and diverse delivery models it may not be worth the trouble to formalize allocation processes. A given service

[43] This argument about quality incentives created by universal services is generally credited to Richard Titmuss: Titmuss RM, Abel-Smith B, Titmuss K. *The philosophy of welfare: Selected writings of Richard M. Titmuss*. London: Allen & Unwin; 1987.

even if outside of medicare may have general principles and a culture of equity that may apply to this as to all its services. A shared standard set by the CHA cannot be assumed in this area; a general culture and specific approach designed to achieve equity must be set by explicit program policy.

Professional athletes and their families obtaining flu shots or medical treatment before the general public access?

I cannot imagine any ethically justifiable resource allocation rule by which professional athletes and their families would receive expedited or preferential access. Even if one were to defend and follow a general rule giving preferential access to those who occupy an elevated social role or exhibit a form of "human excellence," I can see no reason why athletes would be selected as more worthy than other accomplished individuals or benefactors of humanity with large (or small) fan bases.

I can only speculate on practical and sociological reasons why this question would arise. Physicians and other healthcare providers, given their social location, may be particularly impressed by professional athletes, and so more likely to recognize and give expedited access to a goalie rather than a respected elder from a First Nations community, or a world class violinist, or a prominent physicist, or a great tattoo artist (examples chosen to highlight diversity in judgments of social value).

A physician arranging for a friend or family member to be seen quickly?

This is prevalent and widely tolerated in Canada. Although "professional courtesy" is officially considered to be a matter of after-hours appointments (see the Inquiry's further questions below), one might reasonably wonder about the extent to which professional courtesy takes the form of after-hours appointments and to which extent it involves expedited care during normal business hours.

Professional courtesy involves ethical harm. Like access to diagnostic imaging, preferential access to a consult creates upstream inequities in access (to the next stage of services). It seems unlikely that the same physician who is unable to resist a request for an expedited appointment could resist the similar pressure for special consideration in making a referral.

An argument in favour of the acceptability of the practice is that our healthcare system is so badly organized that it is particularly unreasonable to expect fairness to lay a stronger claim than personal loyalty.

I consider it to be another example of improper preferential access based on insider status. My greatest concern about the practice is in relation to the value of social solidarity: widespread use of personal connections to expedited access for insiders and persons of influence contributes to a system in which those with influence exit the public queue and hence have little incentive to advocate to improve the situation.

Politicians/donors/philanthropists being seen in emergency without waiting (depending on the nature of the problem)?

I understand this to be prevalent and widely tolerated in Canada. I consider it, again, to be highly problematic in terms of the public trust, conflict of interest, equity, and solidarity.

Hospitals more or less aggressively fund-raise from former patients. There is nothing wrong with fundraising, but hospitals should want to zealously guard against the appearance that treatment depends on a quid pro quo in the form of donations, in light of their stewardship of substantial resources dedicated to a public good and funded by the taxpayer, and their dependence on public trust. Refusing and being seen to refuse to consider preferential access for donors and philanthropists would be one way of guarding against such an appearance.

What "depending on the nature of the problem" means here is unclear to me. Preferential access for trivial problems and preferential access for serious problems are both problematic.

This is another dilemma where personal relationships of loyalty and gratitude come in tension with fairness and equity.

Again, the principle of solidarity would especially suggest that those with power and voice, who are in the best position to address short-comings of the system – such as donors – should not be offered a view of the system that hides its blemishes.

Are you aware of any safeguards which currently exist in the health care system to prevent "improper" preferential access? If so, do you believe such safeguards to be effective and why?

Well-managed wait lists (ethical criteria and transparent administration) discourage some forms of seeking and granting preferential access. The public can be reasonably confident that their needs will be met in a timely and fair fashion, and so the incentive to seek expedited access is moderated, while healthcare providers are better equipped to resist requests for special access, because they have the assurance that the system is a fair one that ensures appropriate care.

Where such a process is transparent – e.g. a group of cardiologists meets to determine priority access to bypass surgery, or an interprofessional committee meets to determine wait list order for scarce organs according to established and evidence-based criteria – there is less potential for individual wrongdoing than there is where wait lists are at the discretion of individuals within the system.

Regulations on the part of provincial insurers and regulatory college guidelines covering practices that constitute or are relevantly similar to extra-billing are sometimes effective.

Legislation against bribery and influence peddling for public office holders may be effective in controlling some kinds of requests for special access.

Transparent processes such as the application of clear eligibility criteria for safety net coverage (e.g. pharmacare) and the process of transparent and independent health technology assessment (for drugs for provincial or hospital formulary) contribute to preventing improper preferential access to programs and to specific goods and services.

Do you believe that there are changes that can be made to the existing health care system to avoid or prevent "improper" preferential access? What changes would you recommend and why?

Each of these areas is deserving of close analysis, but I make a few comments here about limitations to current mechanisms, and desirable directions of change.

Leadership by the regulatory colleges in defining improper preferential access, as well as institutional policies that clarify healthcare providers' commitment to solidarity with the Canadian public and prohibit preferential access of insiders to the resources they control, could make substantial contributions to addressing this issue.

Self-regulation, however, is an imperfect means to address the tendency of a privileged insider group to give itself additional privileges. It is exceedingly unlikely that, for example, physicians will come forward and report on fellow physicians for giving preferential access to other physicians, or that these practices would be transparent to the public. (This is long-recognized as a problem for self-regulation in general.)

Public and transparent processes of priority setting throughout Canadian healthcare, replacing the *de facto* determination of resource allocation by mechanisms such as non-transparent physician fee negotiations,[44] and the further development of fair and centrally managed wait lists, would contribute to a fair system in which the rules of access could be considered just and worthy of upholding. Again, without transparency beyond the immediate care providers, organized wait lists can leave untouched the tendency of those within healthcare to give people like themselves expedited access.

As physicians operate for the most part as private business entities delivering publicly funded healthcare services with a significant degree of professional autonomy, the use of their position to secure preferential access for themselves, their friends, their associates, and other people who impress them, may not be understood or treated legally as equivalent to a public official's or public employee's use of his or her position to sway access to the public goods over which they have influence – which would be a clear breach of public trust. Indeed, practices of "professional courtesy" are a conscious hearkening back to the days where physician practice was purely a private business affair.

This specific mix of public funding and private delivery in physician services in Canadian healthcare contributes to the sense that access is theirs to grant. Perhaps legislative frameworks focusing on the crime of using a public office to secure personal advantage, rather than focusing on using any office or influence, public or private, to secure personal

[44] Flood CM. Just Medicare: *What's in, what's out, how we decide*. Toronto; Buffalo, N.Y.: University of Toronto Press; 2006.

access to a public resource, also contribute. Furthermore, existing legislation may effectively address explicit requests for favours, but not so clearly address unspoken expectations about preferential access, where the "benefit" traded may simply be avoiding an uncomfortable conversation, enjoying the pleasure of expressing personal loyalty towards associates or gratitude towards benefactors, or facilitating collegial referring relationships aimed at the good of one's own patients.

Legislative or policy changes that provide greater transparency and public accountability on the part of Canadian physicians in their role as *de facto* managers of public resources, whatever their official employment status as private business persons, would contribute to more equitable access and clarity in the grey areas between corruption, conflict of interest, and professional autonomy.

Facilities and hospitals (and their accreditation bodies and regulatory frameworks) can also address these issues. For example, they should support staff in achieving equitable access by showing strong ethical and organizational leadership in relation to the expectations of special access by benefactors and public figures.

Emergency Department Care: Providing high profile people with a separate waiting area away from the general public

A special waiting area is technically an instance of preferential treatment or consideration, but not preferential access to care. Like a private room that can be purchased for a premium, it does not necessarily mean that a person will be cared for better or faster.

The issue here is less one of queue-jumping and more one of the ethos of the institution. Even in jurisdictions with multi-tier care, pressures to deliver luxury care constitute a problem in the inefficiencies they present and the pressure they put on resources that could be used to care for other patients.[45]

An equitable approach at the level of the institution to this policy question would involve questioning who is defined as needing privacy and why (what about the privacy needs of victims or alleged perpetrators of crimes, of people under threat of intimate partner

[45] Donohoe M. Luxury primary care, academic medical centers, and the erosion of science and professional ethics. *J Gen Intern Med* 2004, Jan;19(1):90-4.

violence?), while distinguishing preference and privilege from medical and social need. Learning about the privacy needs of an individual prominent patient can sensitize an institution to the gaps in its privacy practices, such as patient boards with names and room numbers in public access areas, that have significance for all patients.

Emergency Department Care: Providing priority access to care for doctors, nurses or AHS staff and/or family members accompanied by doctors, nurses or AHS staff

I consider this to be the same as other kinds of problematic insider access as has been discussed under several headings. Those who would advocate for the acceptability of "professional courtesy" would be hard-pressed to extend those arguments to preferential access to ED care, as there is no such thing as after hours access that does not bump other patients.

Emergency Department Care: Physicians asking their own patients to go to the ED to receive elective procedures

I am uncertain whether the envisaged scenario is simply one of inefficiency in the organization of the hospital services (presumably admissions for elective surgeries can be handled with less conflict for acute care needs if they are not handled by the ED), or an actual way for people to jump the queue for elective procedures.

It may be in a given area that there is a clinical threshold between a procedure being elective and urgent, and as patients are on the wait list for elective procedures, their acuity may change and they cross this threshold. For patients experiencing such a worsening to present to emergency may be the appropriate care pathway. Encouraging patients reluctant to do so may be an appropriate form of ***advocacy.***

Coaching patients who do not meet such a threshold to present to emergency with the right story to trigger urgent treatment would be ***gaming the system,*** and a form of ***queue-jumping.***

In some areas of care, access may be so poorly organized that physicians have few options to secure appropriate care for patients, and what one physician considers advocacy another considers gaming the system.

Physicians: Responding to requests to see patients in their office quickly by slotting them in before or after normal office hours or on the weekends

This may either describe "professional courtesy" for an associate, or it may be a practice of accommodation for individualized, medically appropriate patient-centred patient care (for example, making special arrangements for a patient with autistic spectrum disorder who is distressed by a busy waiting room).

Where this is a question of professional courtesy, in addition to my answers above in relation to expedited access based on insider status, I add the following considerations:

An after-hours appointment may be "in addition" to the regular patient load, but is nonetheless a publicly-funded service; while some argue that no patients are harmed by being "bumped" when the appointment is after hours (ignoring follow-on effects), nonetheless access to a public resource is preferentially granted to associates.

Alternately, physicians granting appointments based on professional courtesy may elect not to charge (in this case, not to bill the provincial insurer) for such treatment. (This is what the Code of Ethics recommends for emergency care for self or close family members.)

Physicians writing prescriptions or providing medical care for friends, family or colleagues outside of their medical office

This captures diverse phenomena, ranging from acts prohibited by the Code of Ethics (non-emergent care of close family), to a version of what is sometimes discussed in the literature as "curbside" or "hallway consults."

First, treating close family except on an emergency basis is prohibited by the Code of Ethics. The prohibition serves a number of professional, personal, and ethical goals. The close relationship may interfere with unbiased medical judgment, whether by swaying the provider towards imagining the worst or towards denying the gravity of a situation. Any close relationship that would garner access to care is *ipso facto* a form of conflict of interest that may drive care providers to provide disproportionate attention to their friend or family over other patients for whom they have responsibilities. The role conflict affects

the other side of the equation as well: the role of patient or of family member is an equally important role, and one of great personal value within the individual's narrative or family context, and may be sacrificed to the medical role. It is also likely that historical prohibitions on billing for care to family members where it is provided on an urgent basis is a recognition that close relationships create a greater potential for abuse of billing privileges, i.e. a danger zone for corruption.

Second, curbside consults, in the sense of an informal consult about one's own or a patient's medical condition, also known as curbside consults, **are a complex phenomenon.** In the context of ordinary care for a patient who is not a close associate, the physician receiving a request for a curbside consult must weigh the reason for the request (Does the patient or consulting physician have a legitimate or illegitimate reason to try to keep the consult off the record?). The risk of harm and legal liability assumed by undertaking care outside of a clear physician-patient relationship and with what may be inadequate instruments and information must be considered. On the other side, one's responsibilities to participate in a collaborative learning community and avoid excessively conservative risk management must also be considered.[46]

In the context of care for self and families, the question arises whether foregoing the physician-patient relationship for informal consultation constitutes an adequate form of self-care: the practice of consulting informally rather than pursuing care through a consistent physician-patient relationship is discouraged.[47]

All examples in this area must be contextualized: we live in an era where, as "activated patients," we seek information from multiple sources to enhance our health. We ask friends and family with experience with a condition for advice, and similarly we ask friends

[46] Leavitt FJ, Peleg R, Peleg A. Informal medicine: Ethical analysis. *J Med Ethics* 2005, Dec;31(12):689-92; Perley CM. Physician use of the curbside consultation to address information needs: Report on a collective case study. J *Med Libr Assoc* 2006, Apr;94(2):137-44.

[47] Roberts LW, Warner TD, Carter D, Frank E, Ganzini L, Lyketsos C. Caring for medical students as patients: Access to services and care-seeking practices of 1,027 students at nine medical schools. Collaborative research group on medical student healthcare. *Acad Med* 2000, Mar;75(3):272-7; Walter JK, Lang CW, Ross LF. When physicians forego the doctor-patient relationship, should they elect to self-prescribe or curbside? An empirical and ethical analysis. *J Med Ethics* 2010, Jan;36(1):19-23.

and families who are healthcare providers with experience in care provision.

Healthcare providers, in the process of socialization to their profession, learn to set and communicate boundaries in such conversations. This is often discussed in relation to good patient care (the risk of informal second opinions without good information and under the influence of personal relationships that may bias clinical thinking) and self-care (the need for "time off" the physician role).

Private Health Care Facilities: Do membership based private health care facilities constitute an example of preferential access?

Where these facilities deliver extended or excluded services under the CHA, there is nothing to prevent health professionals from operating and patients from joining membership-based facilities that provide, for example, physiotherapy, massage therapy, nutritional counselling, chiropractic care.

Given the room left by the CHA for extensive diagnostic workups by physicians and for diagnostic imaging and other kinds of testing to be done by private pay, these practices create the potential for created expedited access to the public system. Potentially problematic practices are reviewed above in Table 6.

Boutique medicine, in the form of a membership-fee-based physician practice, is an area of policy concern in some provinces, particularly where market conditions support the development of such models.

Regulatory colleges have typically, and appropriately in my view, clarified that where a funding for a service falls under the CHA, offering access or expedited access to this service based on the payment of a fee is a form of improper preferential access, in specific, a form of extra-billing. They have also clarified that services offered bundled must also be available unbundled, and patients may not be excluded from a physician's practice for refusing to pay for bundled services.[48] Enforcement varies from jurisdiction to jurisdiction.

[48] See, for example, College of Physicians and Surgeons of Alberta. Standard 18: Charging for uninsured services. Standards of practice [Internet]. Edmonton AB: CPSA; 2010 [cited 2012, Nov 25]. Available from:

While regulatory colleges have been clarifying that physicians may not establish such boutique practices, I do not believe they have adequately characterized and regulated multi-disciplinary and corporate practices where physicians may provide a limited set of services and only to patients of that membership based facility. Does the responsibility not to create financial or other barriers to care follow the physician into that multidisciplinary setting and compel it to adopt a certain access model, or may the physician split their time between practicing in such a setting and in the public setting, as they may do for a range of non-insured services (e.g. cosmetic surgery)?

I believe that we have blatant double standards in this area, and that it will be challenging to regulate this effectively under the framework of Canadian medicare.

MLAs or their Staff: Providing advice to their constituents about wait times, alternate care options etc.; Requesting special consideration for a constituent by communicating directly with a health care provider

In general, as suggested above, one can distinguish ethically acceptable advocacy in terms of navigation and sharing of information from ethically unacceptable advocacy such as calling in special favours or exercising personal or political pressure. It would be difficult to imagine a scenario where direct communication from a political figure to a healthcare provider would be anything but the latter. The MLA who wants to advocate for patients should advocate for decent treatment of patients as a class, not for special treatment of specific patients.

Senior Hospital or Health Authority Officials: Requesting special arrangements (eg: private room, anonymity etc.) for a VIP or high profile patient

This is similar to the questions about a separate waiting room in the ED: they are less questions of equity in access and more of equity in experience of care. Someone in a private room is not necessarily receiving faster medical care or a higher standard of medical care.

http://www.cpsa.ab.ca/Libraries/Res_Standards_of_Practice/CPSA_Standards_of_Practice_Consolidated_Version.pdf; College of Physicians and Surgeons of Ontario. Block fees and uninsured services [Internet]. Toronto: CPSO [cited 2012, Nov 25]. Available from: http://www.cpso.on.ca/policies/policies/default.aspx?ID=1612.

In hospitals, patients may and do purchase private rooms where this is medically possible.

All patients have needs of privacy and confidentiality. A high profile patient may make this clear to providers and institutions, but equally an "ordinary" patient who is threatened by an ex-spouse (for example) has privacy needs that may not be met by common hospital practices.

Calling front line staff to make them "aware" that a VIP patient is in the hospital or in the system

It would be irresponsible to make such a call without a defined and stated goal; front-line staff would reasonably conclude they are being asked to deliver special treatment.

If a patient who would cause disruption in terms of media interest, law enforcement, or security needs is entering the hospital, then communicating this may be important, but accompanied by specific instructions or policies as to the nature of the concerns and accommodations to be undertaken.

If the provision of care in a particular area is so inadequate that administrators feel it is not appropriate for or not desirable to be seen as the norm by VIP patients, then this is a signal for much broader action.

I discussed above the responsibilities to provide patient-centred and culturally sensitive care. It is important to distinguish the responsibility to accommodate a patient's "special needs" in a sense that promotes health equity from the desire to accommodate a patient's "special needs" when this is a cynical label for the requests of VIPs for extra or expedited care. The former promotes health equity and the latter promotes health inequity.

(b) Preferential Access to Health Care Services in Alberta, An Opinion

Dr. John Church

Overview

The issue of preferential access to health care is nested within the larger issue of access to health care. In Canada, access to health care is prescribed by federal legislation, the *Canada Health Act*, and also through individual provincial and territorial legislation. The *Canada Health Act* prescribes that all insured persons have "***reasonable access***" to healthcare facilities and that hospitals and physicians are reasonably compensated for providing this access. The Act also prescribes that access to publicly funded health care will be determined by "***medical necessity***." In practice, physicians determine medical necessity based on their recognized expertise. The gatekeeper role is sanctioned by the state on behalf of its citizens. The key point here is that physicians make decisions about who will access health care, what type of health care and when that health care will be accessed based on criteria related to the severity of illness, not the ability to pay or other "non-medical" criteria.

In practice, physicians have a professional obligation/responsibility to advocate for the best health care for their patients. This includes attempting to gain access to appropriate health care in a ***timely*** fashion based on professional judgment about the severity of the illness and what is medically required to resolve the issue. Individual family physicians develop professional relationships with individual medical specialists based on a number of factors including professional reputation, availability and geography. Thus, family physician A may develop a relationship with medical specialist B and will tend to refer patients routinely to that specialist. Family physicians will have a back up plan for referral to an alternate medical specialist should the usual specialist referral not be available. Family physicians also develop similar relationships with other occupations such as physiotherapists.

Within this context, individual physicians can gain access to health care for *their* patients through a variety of avenues, depending on their connectivity to different parts of the healthcare system. The key point here is that the motivation of the physician is to advocate on behalf of

their patient for access to ***medically necessary*** health care based on ***severity of illness*** as determined by professional judgment.

Even under normal circumstances, there may be variability in access based on the nature of the way in which individual physicians discharge their responsibility. Variation may occur as a result of a number of factors including the availability of the family physician and/or the specialist and the severity of the illness compared to other patients being seen by the family physician or the specialist. Thus, a form of preferential access may and does occur based on how individual physicians exercise their clinical judgment, navigate the system, and based on severity of illness and availability of resources such as diagnostic imaging and hospital beds. This form of preferential access is commonly recognized as acceptable and is foundational to the healthcare system in Canada. International evidence is clear that this approach to allocating health care produces better results than other possible alternatives.

A second form of preferential access relates to the notion of professional courtesy[1], a time-honoured practice of referring family members to other physicians in exchange for the same courtesy. This stems from the ethical requirement of not treating one's own family members and the professional desire to build bonds among individual practitioners.

Taking the above as representing what would normally be considered as acceptable access, are there additional, non-medical criteria that might be applied in determining when preferential access to health care is appropriate? One circumstance in which preferential access to medical health care might be warranted would be for workers deemed as providing an ***essential service***. Included in this category might be health care providers (doctors, nurses, other core medical providers), emergency service providers (EMTs and firefighters), law enforcement (police) and senior politicians (PM, premiers and cabinet ministers).

This sort of preferential access would be particularly important during times of recognized collective crisis (pandemics, war or terrorism or catastrophic natural disasters). An argument might also be made that immediate family members of certain essential service workers (e.g.

[1] Professional courtesy is not unique to medicine. It is a practice common to many occupational groups ranging from lawyers to mechanics.

medical specialists) also be granted preferential access, especially if the illness of the family member is severe enough to prevent the essential service provider from discharging their normal professional responsibilities. Again, during times of crisis, this would be particularly important.

Criteria that might be used to determine when preferential access might be appropriate for essential service workers might include: the nature of the service being provided (how essential is the service?); the context under which preferential access is being sought (e.g. pandemic); the consequences of denying preferential access (e.g. denial or delay in accessing essential services by other members of the public possibly resulting in injury or death).

The Questions:

Keeping the above discussion in mind, we now turn to a discussion of the seven questions raised by the Inquiry.

1. At the current time, there is no common definition of preferential access. We know from research that access to health care is affected by a variety of factors including socio-demographic status, and ethnicity. In short, some individuals are better able to access health care than others, although in Canada, ability to pay has been eliminated for core medical services. Having said this, the only clear definition that exists at this point relates to ***appropriate access***. This definition revolves around the concepts of medical necessity and severity of illness as determined by physicians.

2. Without a clear definition, determining "proper preferential access" and "improper preferential access" revolves primarily around the definition and criteria assigned to appropriate access as defined through the *Canada Health Act* and other provincial legislation or regulations. However, most if not all of this revolves around the interpretation of physicians based on professional judgment. At the very least, under the existing legislative framework, access to publicly funded health care that violates the principles of the *Canada Health Act* would constitute inappropriate preferential access (e.g. queue jumping). So, access to health care for reasons other than medical necessity as determined by a physician or other designated health care provider and/or access to publicly funded

health care based on ability to pay would constitute inappropriate preferential access. The one caveat to this principle might relate to certain categories of workers deemed essential as described above.

3. "Proper" preferential access to health care might include anything deemed by a physician or other duly designated health care provider to be medically necessary based on the severity of illness. Making this determination should be based on clearly established clinical criteria that meet professional quality assurance requirements. The potential harm associated with this approach to accessing health care is that some patients receive preferential access to health care over others. However, the criteria used for making this determination are both ethical and practical.

4. "Improper" preferential access would refer to access to health care based on criteria other than medical necessity and severity of illness based on recognized professional clinical judgment. So, accessing health care through "threat, influence or favour" would be considered improper. Interestingly enough, the small amount of research that has been done in the Canadian context suggests that while supporting this notion in principle, a minority (not socio-demographic specific) of the public-at-large is willing to pursue preferential access to health care based on criteria other than professional clinical judgment. Other very limited research within the Canadian context suggests that politically connected individuals are more likely to receive preferential treatment than other members of the public.
 The harm in allowing preferential access to health care is that it undermines the principles of the *Canada Health Act* and ultimately undermines public confidence in the healthcare system.

5. i) As discussed above, physicians have a professional obligation/responsibility to advocate on behalf of their patients for appropriate access to medically necessary services. The recognition of the expertise of physicians in determining what constitutes disease and how best to treat it has been broadly acknowledged by Canadian society for over 100 years. The granting of self-regulation to Organized Medicine by Canadian governments is formal recognition of the collective

trust that Canadians place in the capacity of physicians to represent their best interests in decision making about health care. Unless the knowledge base underlying health care alters significantly, it would be difficult to envision a superior means of advocating for patients, although discussions about which professions are qualified to exercise clinical judgment in this role are ongoing.

ii) Physician use of emergency OR slots to book patients in for surgeries represents one of the practical means by which physicians advocate on behalf of their patients for appropriate access to health care. The practice has emerged largely because of increasing wait times for access to certain medical procedures. Whether this is "proper" or "improper" depends on one's perspective. From the point of view of the physician fulfilling their professional responsibility, it is proper because it expedites the process of getting **their** patient in for appropriate health care. From the perspective of the system administrator, it increases the volume of patients being seen in emergency rooms and contributes to increased wait times at this point of access to the system. The underlying issue of wait times is discussed further below.

iii) As discussed above, allowing a physician or other health care provider to obtain an MRI faster than spending time on a waiting list is probably appropriate when failing to do so might adversely affect the provision of health care to other patients. One can imagine a circumstance in which a heart surgeon is unable to perform heart surgeries because of a deteriorating hip. In this case, diagnosing and treating the heart surgeon as quickly as possible is in the best interests of everyone. However, not all circumstances merit the same consideration for expedited health care.

Another category of workers currently receives preferential access because of coverage through Workers' Compensation Boards. Because these services are financed separately from public-financed services they create a parallel but institutionalized pathway for preferential access to health care services. The appropriateness of this access is a subject of debate. As with other categories of workers, the case needs to be made about the relative societal benefits of expedited access to healthcare services.

iv) Hospital and medical staff who are deemed essential workers should obtain flu shots prior to the general public. The definition of "essential" should consider the collective benefit of providing this sort of preferential access. Not all hospital and medical staff are a *priori* essential.

v) Professional athletes and their families do not meet any reasonable definition of an essential worker as described above. Thus, preferential access to publicly funded health care by these individuals would be generally considered as inappropriate.

vi) A physician arranging for a friend or family member to be seen quickly might constitute part of the tradition of professional courtesy. Regardless of the personal relationship, if the decision is not based on objective clinical judgment about medical necessity and severity of illness, then it might be considered inappropriate. As discussed above (#4), limited research suggested that a minority of the population (not socio-demographic specific) is willing to pursue this avenue in order to expedite the process of accessing health care.

vii) As discussed above, certain categories of politicians (e.g. PM, premiers and cabinet ministers) might ethically and practically be considered essential workers. Preferential access would depend on the severity of the illness and the context within which the request was being made (e.g. national/provincial crisis). Financial donors and philanthropists do not constitute essential workers by any reasonable definition and therefore do not merit consideration for preferential access.

Additional Sub-Questions

viii) Providing priority access in the emergency room for doctors, nurses, AHS staff and/or family members, or a physician's patients, accompanied by a physician, nurse or AHS staff would only be appropriate if clear criteria for medical necessity and severity of illness relative to other patients in the emergency room at the time were met. Alternatively, if failure to provide such preferential access would prevent an essential worker from carrying out their

duties and place other members of the public in danger (as discussed above), then preferential access would be justified.

ix) Responding to requests to see patients in their office quickly by slotting them in before or after normal office hours or on weekends would not be justified except as discussed below (x). Doing so might call into question the lack of availability of the physician to all patients during non-scheduled office hours. A physician might offer a home visit or on-call service to all patients after hours to ensure equal access.

x) Physicians writing prescriptions or providing medical services for friends, family or medical colleagues outside of regular office hours might be allowable as a professional courtesy as long as it does not compromise availability of care for regular patients. Within reason, a physician's private time is his/her own. However, providing medical care to a family member may constitute a breach of the medical code of ethics.

xi) Recently, a number of private companies have begun to offer comprehensive health care packages to individuals based on an annual membership fee. These arrangements have been the subject of ongoing monitoring as potential violations of the *Canada Health Act*. It has been alleged that some of these companies in Alberta have engaged in queue-jumping for certain advanced diagnostic testing provided through the publicly funded system. If these allegations are demonstrated to be true, then it would constitute inappropriate preferential access. Depending on the circumstances, it might also constitute medical conflict of interest and be in violation of the *Canada Health Act*. The only caveat here would be if the access provided was based on clearly demonstrated medical necessity and severity of illness relative to all other patients waiting for the same diagnostic test at the same location.

xii) An MLA or political staffer providing advice to their constituents about waits, alternative care or other health care options would not be considered as inappropriate preferential access. Providing this sort of information on other government services is an important part of the legitimate role performed by MLAs. Also, AHS and Alberta Health provide various online resources for determining the length of wait times for

various surgical procedures and also for access to emergency care. Increasing emphasis is now being placed on making this sort of information more readily available to the public.

xiii) An MLA or political staffer contacting a health provider to request expedited access for a constituent would be inappropriate unless justified through demonstrated medical necessity and severity of illness criteria relative to all other patients awaiting access at the same facility.

xiv) Providing high profile individuals with special treatment, such as a separate waiting area, private room, anonymity or a "heads up" call from senior management to front-line staff, would constitute inappropriate preferential access. The only exception to this would be if failure to make these arrangements might pose a clear safety risk for the individual, other patients, other members of the public and health providers, or otherwise disrupt the efficient provision of health care services.

6. In 2009, Alberta Health Services issued guidelines relating to dealing with requests for preferential or expedited health care. While the guidelines served as a useful starting point for identifying the issue, they did not prescribe an appropriate response with sufficient transparency. Referring the matter directly to "the President and Chief Executive Officer of Alberta Health Services" and/or providing "advice as to how to most effectively access and navigate the provincial health care system" might still be construed by the public as facilitating preferential access to health care.

7. Based on the discussion provided in this opinion, changes need to be made in the way preferential access to health care is addressed. These changes include developing the following:

 - clear guidelines and protocols (including compliance tracking) for the application of the concepts of medical necessity and severity of illness;
 - a definition of appropriate and inappropriate preferential access, and related criteria;
 - a definition of essential workers and related criteria;

- a transparent, clear and effective process for administering these definitions and criteria; and
- a transparent, clear and effective process for determining wrongdoing, including whistleblower protection and serious penalties for demonstrated wrongdoing.

Concluding Thoughts

The issue of preferential access to health care in Alberta has arisen primarily because of publicly unacceptable wait times for access to health care services. If wait times were at an acceptable level, then presumably efforts to gain preferential access would no longer be necessary. Therefore, efforts to reduce wait times to acceptable levels must continue regardless of appropriately addressing the specific issue of preferential access. Addressing the issue of preferential access now is essential because it potentially violates the *Canada Health Act* and undermines confidence in the publicly funded health care system.

Having said this, efforts to address wait times have tended to be focused fairly narrowly on developing administrative and clinical solutions to dealing with wait lists and surgical management. Far less attention has been directed toward the broader organization of the continuum of health care and its impact on access to services. Even less attention has been focused on the role that prevention of injury and disease might play in reducing wait times. We know that injury rates in Alberta are high relative to other jurisdictions; we know that with an aging population we are facing more complexity in illness; we know that chronic diseases such as obesity are on the rise, especially among younger populations; and yet we are not devoting sufficient resources to address these contributing factors to current and future demand pressures on the system. Failure to get serious about these broader population trends will almost certainly mean that demand pressures on the system will not decrease. In turn, this will lead to continuing unacceptable wait times and a continuing pressure for preferential access.

Dealing with the issue of preferential access to health care represents treating a symptom related to a larger disease. If serious strategies to address the larger disease are not developed and implemented, the symptom will likely continue in some form.

Recommendations

1. Develop clear guidelines and protocols (including compliance tracking) for the application of the concepts of medical necessity and severity of illness.
2. Develop a clear definition of appropriate and inappropriate preferential access.
3. Develop a definition of what constitutes an essential worker.
4. Develop a transparent and fair process for administering these definitions.
5. Develop a transparent and fair process for determining wrongdoing, including serious penalties.
6. Develop effective whistleblower protection.
7. Develop effective strategies to address wait times.
8. Develop a comprehensive and **well-resourced** wellness strategy.

(c) Responses to Preferential Access Questions

Dr. David Alter

LIST OF QUESTIONS TO BE ANSWERED BY EXPERTS

1. What is "preferential access" to health care?

I am unaware of any uniform definition of preferential access. However, within the Canadian context of universal health care, our previous study ("A Survey of Provider Experiences and Perceptions of Preferential Access to Cardiovascular Care in Ontario, Canada", David A. Alter, MD; Antoni S.H. Basinski, MD, PhD; and C. David Naylor, MD, DPhil, *Ann Intern Med.* 1 October 1998;129(7):567-57) defined preferential access as incidents which result in unreasonable access to medically necessary services that allows for either more expeditious or wider use of services based on perceived socioeconomic status or for other non-medical reasons (family of staff, VIP, socioeconomic status etc.).

i) Is there a common definition?

Not that I am aware of.

2. Is there a difference between "proper preferential access" and "improper preferential access"?

The distinction between proper and improper preferential access in part depends on how one interprets the appropriateness of access equity. Accordingly, I will begin by referencing the definition of the *Canada Health Act*, and bold some key phrases:

> "Canada's national health insurance program, often referred to as "Medicare", is designed to ensure that all residents have ***reasonable access*** to ***medically necessary hospital and physician services***, on a ***prepaid basis***. Instead of having a single national plan, we have a national program that is composed of 13 interlocking provincial and territorial health insurance plans, all of which share certain common features and basic standards of coverage. Framed by the *Canada Health Act*, the principles governing our health care system are ***symbols of the underlying Canadian values*** of equity and solidarity."

The definition of preferential access is therefore open to considerable debate, and hinges on a few key issues or phrases as highlighted above: (1) "reasonability"; (2) "pre-paid payment"; (3) medical necessity; and (4)…framing the symbolic Canadian values of equity and solidarity. I will begin with the fourth issue first. I am not sure that symbolic goals are enforceable, definable, or indeed, an underlying Canadian value. While few would question the importance of many of the strong social policies that govern our country (and specifically, Medicare), I am not certain how such principles are to be interpreted within the *Canada Health Act*.

Do the symbols that underlie Canadian values truly reflect equity? There are many examples to the contrary. For instance, income expectations are not equal. Similarly, primary priorities of Canadian taxation policy solutions are not necessarily hinged on income redistribution strategies to improve equity. Do we, in Canada, discourage free-markets? Do parallel private systems not exist within other social programs like education? Does pubic-funding towards social programs for education cover all religious preferences? etc.

So, in reality, Canadian values, as observed by actual behaviours and policies do not necessarily reflect "equity" per se. In my opinion, the fourth issue of equity is actually one of the weakest arguments when debating the appropriateness or inappropriateness of preferential access. I am not a bioethicist, but equity alone seems unreasonable to be used to define or evaluate the presence or absence of "proper" or "improper" preferential access. Rather, preferential access must be evaluated within the context of the other issues specified within the *Canada Health Act*.

In distinct contrast to the issue of equity, is the issue of pre-paid payments. Out-of-pocket payment for Medicare-covered services would be considered illegal (at least in Ontario). Consequently, pre-paid payments from first-payers in order to expedite access would, by definition, be "improper". However, there are circumstances where third-party payments are not illegal. Accordingly, legal third party payments used to expedite access and circumvent long waiting-lists do occur. An example might include a professional sports team and access to MRIs. In my opinion, as long as this is legal, such preferential access is not improper.

The remaining issues pertain to issues of "medical necessity" and "reasonable access". In my opinion, the crux here is that all patients in need of service should receive "reasonable access" to the service in question. So, any access afforded to individuals who are not in need of service, or preferential access for some resulting in unreasonable access delays for others in need of service would be considered "improper". The challenge here, however, is that such a supposition assumes that "medical necessity" and "reasonable access" are quantifiable. For many (if not most) procedures/services, such terms have neither been quantified nor defined explicitly. Medical necessity may, in theory, involve an array of symptoms or signs. Examples include the following: An asymptomatic patient in need of service for screening; a highly symptomatic patient in need of Medicare services for symptom-control; and those who experience mental or psychosocial distress as a result of illness, symptoms, or screening. All such examples could be considered as "medically necessary". How then do we prioritize these medically necessary, but highly variable indications? And, who decides?

For waiting-times to be considered "reasonable", one presumes there must be standards for waiting-time acceptability. One might logically assume that waiting-time acceptability be defined in accordance to an agreed upon definition of medical necessity. For this to occur, one would assume that there must be an organizational process in place which prioritizes and delivers services in accordance to such acceptable waiting-times. While national wait-list strategies have attempted to set standards for waiting-times for selected services, few waiting-lists are explicitly managed in accordance to need. Without such mechanisms in place, "preferential access" will exist and is challenging to define operationally and prevent.

The distinctions between "proper" and "improper" preferential access remain unclear and ambiguous. The assessment of whether preferential access is "proper" or "improper" likely necessitates some legal and ethical conceptual framework. The former (legal) is fairly easily discerned. The latter (ethics) is more difficult, in part because ethics will vary by stakeholder groups. From a societal perspective, an improper example of preferential access may be a circumstance where an individual jumps several places in the queue despite objectively having similar disease severity as others who wait. Is that unethical? Not necessarily, for several reasons: First, it assumes that there is an explicit prioritization system in place within the queue that takes into

account all clinical and potentially important non-clinical (e.g., distance and capacity) factors. Second, it assumes that the queue is organized in such a way that there is no flexibility in movement and that pushes and pulls are impervious and impenetrable within the management of the waiting lists. This is likely an unrealistic assumption. Third, it assumes that patient's clinical status and priorities remain static, and that medical personnel and system managers don't or can't respond to non-clinical extraneous factors that place added pressures or expectations to expedite care. Fourth, it assumes that the objectives and goals of an individual are always aligned with that of the system. Such is not always the case, especially since patients (and their families) self-advocate for care. Moreover, health care providers, public health advocates promote appropriate health-seeking behaviours. Reconciling differences between the needs of the individual and the needs of the system are challenging. Finally, no two individuals will experience the symptoms and/or psychosocial impact of disease. Accordingly, no two patients are entirely equal with regards to symptoms, experiences perceived, and its psychosocial impacts on health status and quality of life.

The example of a patient who is waiting to be seen in a busy fracture clinic, who then, after waiting hours, tries to self-advocate and expedite his/her own care because of non-clinical issues, such as his/her fear of missing his/her scheduled transportation with Wheel-Trans (a publicly-funded transportation service for those with disability) serves to exemplify the complexity of a queue. Is providing preferential expedited care for transportations reasons wrong? Is it inappropriate for patients to self-advocate? Who judges what is and what is not a valid reason to push ahead and receive preferential access? Do we really believe that we can prevent such pushes and pulls?

In reality, no queue is organized as a lineup. There are always circumstances, some of which are resource-based, while others administrative or personal, which will result in some patients being serviced ahead of others, even where clinical severity can be measured, and be deemed objectively comparable.

3. In your opinion, what would be examples of "proper" preferential access to health care?

It is my opinion that preferential access is "proper" because it reflects reality. In our survey of preferential access, we noted that over 80% of

Ontario physicians acknowledged having been personally involved in cases where preferential access for patients occurred. The issue in my opinion is not one of preferential access appropriateness or equity, but rather one that ensures that all patients in need of medical services receive reasonable access to such services without user fees or out-of-pocket payment. While access equity may be an aspiring goal of Medicare, it is neither realistic nor practical. Indeed, a "proper" preferential access circumstance might include virtually any example of self-advocacy. If patients advocate on behalf of their own health (which is something we as practitioners encourage), then is it not appropriate that they advocate for the best access that will improve their own health?

I also believe that preferential access based on personal connections is not necessarily improper. A patient who is sick who tries to expedite his/her care by involving a personal friend/doctor to advocate for them is not necessarily improper for the reasons discussed above. Is there evidence that people who push the system actually receive preferential access? In our survey above, health care providers made special note of "squeaky wheels" who often receive preferential access. It is not coincidental that "squeaky wheels" often receive preferential access to other services outside of our health care system. Is this "improper"? Why would we not expect that such societal patterns that result in individuals seeking expedited services outside of medical care not filter into their seeking behaviours within our health care system? Who should stop this? And why?

Finally, one can argue that in reality, our society already has multiple tiers and inequities. For example, urban patients will receive preferential access to services than that of their rural counterparts who experience longer waiting-times and less frequent services. Is this improper? No. Might this mean that more services are required to care for rural patients? Yes.

i) Is there harm to the public health care system associated with "proper" preferential access to health care?

Harm to public health care system originating from proper preferential access might be expected to occur when access to services are particularly constrained and where patients may experience adverse outcomes as a result of delay or an underuse of services.

ii) In your opinion, what is the nature of that harm?

Death, re-hospitalization, symptoms (e.g., pain limiting mobility), quality of life. There may also be the issue of perceptions of bias for individuals receiving and not receiving preferential access. While speculative, for some, there may be an expectation or sense of entitlement for preferential access. For others not receiving preferential access, people could feel a sense of partiality, unfairness, or bitterness if they knew that others of similar severity received services more expeditiously.

iii) Is that harm acceptable from an ethical or practical perspective?

In my opinion, when harm manifests in adverse clinical events, then the harm from preferential access is not acceptable. However, from a practical standpoint, I'm not sure that harm results from inequity itself. While there is evidence that access inequalities to health care may impact on health outcomes, these circumstances usually occur at extremes of care – for example, patients who are in critical need of a cardiac procedure who, for one reason or another do not receive any such service whatsoever, and consequently, succumb to their disease. One might reasonably hypothesize that the relationship between variations in access and outcomes become weaker among populations who are less ill or sick. Moreover, there is little or no evidence to suggest that health is deleteriously affected by the occurrence of preferential access itself. Simple differences in waiting-times may only impact on the health status of selected individuals within the population – namely those who are critically ill, and/or those for whom service delays are so excessive that delays lead to significant exposure to adverse events. For many of these individuals, symptoms may change and worsen while waiting. Invariably, patients whose symptoms status worsen while waiting in the queue for a particular service should serve as an "alarm" and in turn trigger more expeditious care. Currently, waiting lists are not sufficiently organized to even monitor, service, and prioritize according to clinical need, let alone changing clinical needs.

Perhaps one may argue that the issue of "inequity" itself is unacceptable when there is a public expectation that health care delivery is (or should be) equitable. Should this expectation be reinforced by governments, media etc., then perhaps from an ethical

perspective, herein lies the exception where inequity itself is unacceptable and harmful (particularly in a publicly-funded system which is ostensibly funded by the tax-payer). However, in the absence of such expectations, then inequity itself is not, in my opinion, an example of "harm".

4. In your opinion, what would be examples of "improper" preferential access to health care?

Any circumstances which are illegal. For example, financial gains from "under the table" payments to expedite medical services would be an example of "improper" preferential access. As suggested above, patients who experience delays as a result of preferential access and consequently, experience adverse clinical events resulting from significant delays would be an example of "improper" preferential access. Finally, from an ethical standpoint, improper preferential access could exist from a societal perspective should public expectations, as reinforced by governments and health policy stakeholders, suggest that access to medical services be equal when in fact it is not.

i) Is there harm to the public health care system associated with "improper" preferential access to health care?

Improper preferential access from illegal payments has logical harm to the public health care system and to society as a whole. Harm to the public health care system can also occur when patients experience adverse events as a result of service delay as a direct consequence of preferential access.

ii) In your opinion, what is the nature of that harm?

Suboptimal health outcomes from those adversely affected by excessive service delays.

iii) Is that harm acceptable from an ethical or practical perspective?

No.

5. In your opinion, would you characterize the following examples as "proper" or "improper" access to health care? [Explain with reasons where applicable]

i) Physician advocacy? Is this a good thing? Why or why not?

"Proper." Physicians should be advocates for their patients.

ii) Physician use of emergency OR slots to book patients in for surgeries?

"Proper maybe." I do think there is an implicit unfairness should the patient's level of clinical severity be far lower than their more urgent counterpart, and that delays incurred through the use of emergency OR slots might realistically result in adverse outcome events in others due to "access delays".

iii) Allowing a physician or hospital worker to obtain an MRI faster than spending time on the waiting list?

"Not improper." But, it depends on the perspective stakeholder. If a non-physician or non-hospital worker knew that his/her spot was altered because of a physician or hospital worker, one can certainly understand that that individual might be justifiably upset. However, from a system perspective, such preferential treatment represents a reality. Accordingly, it is the system which must "factor in" and consider such circumstances so that waiting-lists still have the flexibility to adequately service the queue despite the presence of preferential access for some.

iv) Hospital or medical staff obtaining flu shots before the general public?

"Proper." Front-line workers at increased risk for exposure.

v) Professional athletes and their families obtaining flu shots or medical treatment before the general public?

One might argue that professional athletes are at high risk due to public exposure from travel and occupation. That said, professional athletes are not at higher risk for influenza-related complications than other populations such as the elderly, those who are immune-compromised, and/or those with multiple chronic diseases. Accordingly, from a

medical appropriateness standpoint (more so than a preferential access standpoint), I think that professional athletes should not trump high-risk populations when obtaining flu shots. Certainly in the setting of flu vaccine shortages, I do not think that it would be proper for athletes to receive flu shots prior to high-risk populations. However, when compared with the general public, one might argue that they are at higher occupational risk from influenza than the general public.

vi) A physician arranging for a friend or family member to be seen quickly?

I think it's a reality of society - therefore not improper - but it depends on the service and the way in which that service delivery is organized. In the absence of explicit management criteria, for instance, I think the issue is not one of equity. Indeed, the issue is not so different from physicians who advocate for preferential services on behalf of their colleagues. These are natural social phenomena, and advocating for family and friends are natural for our society. However, in circumstances where patients are formally wait-listed in accordance to medical need, and someone usurps this because of preferential access, then the issue becomes problematic. When patient outcomes are adversely affected by delays that result from preferential access, then it should signal that resources may be too constrained and limited to the point that it doesn't allow for sufficient flexibility of movement and pushes/pulls that results from self-advocating or advocating on behalf of others (due to personal relationships or otherwise).

vii) Politicians/donors/philanthropists being seen in emergency without waiting (depending on the nature of the problem)?

I suppose it's perhaps hypocritical and disingenuous to state that preferential access should not be allowed for politicians and others, when I've stated that it is not improper for preferential access to be provided to physicians. However, there is a sense that people in public service using their political influence to self-advocate for, or advocate on behalf of others, expedited medical care access seems troubling (i.e., since politicians in theory are servicing the public good and in such circumstances would be using their position for personal gain with the consequences of added-strain to a health care system funded by the public-payer). That being said, once again, it's a reality. I have tended to politicians who received "red-carpet" access and care. I have

accepted that it was the reality. The same holds true for donors and philanthropists.

ADDENDUM QUESTION 5:

In your opinion, would you characterize the following examples of access to care as:

- ***Preferential access or not preferential access;***
- ***If you determine it to be preferential, is it "proper" or "improper?" Please explain, briefly, the reasoning behind your opinion.***

Emergency Department Care

Providing high profile people with a separate waiting area away from the general public

No. In my opinion, waiting areas are not directly related to the provision of health care services. I would view separate waiting areas in a similarly to private rooms, which are often covered under personal or third-party payer insurance. That being said, I'm not sure how "high profile people" would be identified and characterized. Therefore, operationalization of separate waiting areas could be challenging.

Providing priority access to care for doctors, nurses or AHS staff and/or family members accompanied by doctors, nurses or AHS staff

If the question here relates to priority access to care for doctors, nurses or AHS staff, then I would characterize this as preferential access, as discussed in answers to question 5 iii. Alternatively, if the question here relates more specifically to the issue of accompaniment by doctors, nurses, or AHS staff, then I would not necessarily characterize this as preferential access, since accompaniment can simply serve as supportive roles for their colleagues (similarly to any personal supportive roles in health care settings), and does not necessarily imply that doctors, nurses or AHS staff who accompany other health professionals in the ED are expediting access to care. If access to care were being expedited, then this would be an issue analogous to 5 iii,

and consistent with preferential access. The line of reasoning follows the previous responses given.

Where doctors, nurses or AHS staff uses their influence to expedite emergency room care, then such actions could be deemed as either "proper" or "improper", depending upon the acuity of the patient in question, the general acuity of the other patients in the ED and ED capacity during the time of presentation. For example, a physician who accompanies his/her colleague to ED with an acute myocardial infarction and attempts to expedite care may not be inappropriate, because this would be seen as a life-threatening high acuity situation. However, a physician who tries to expedite access to ED services for a colleague who is experiencing knee discomfort and is otherwise of low acuity may be inappropriate, depending on the acuity of other patients and the availability of ED staff.

As in other examples of preferential access, colleagues do tend to help colleagues when medical issues arise. This may apply to the ED as well, and as long as other patients are not adversely harmed by the expedited access, I would view this as proper preferential access. In contrast, in circumstances where physician's influence is used to expedite ED access for colleagues of low acuity levels thereby resulting in excessive treatment delays and adverse outcomes in patients whose acuity levels are higher, this would, in my opinion exemplify improper preferential access.

Physicians asking their own patients to go to the ED to receive elective procedures

This may or may not represent preferential access, depending on the clinical scenario, the rationale for referral, and procedure in question. This scenario seems may be better addressed under issues of referral appropriateness more so than preferential access. A physician who advises patients to go to the ED for non-emergent or non-urgent matters may be more indicative of inappropriate care than preferential access per se. Moreover, a physician referral to the ED does not necessarily imply that a patient will be given preferential access. The ED triage process tends to be variable, and the degree to which outside physicians may have influence on this ED triage process will also vary widely. ED triage processes may also filter-out elective from more urgent cases, and referring physicians may be implicitly taking such considerations into account when referring patients into ED.

Beyond inappropriate referral patterns, there may be other mitigating circumstances that necessitate physician referrals to ED for elective procedures. For example, physicians may send their patients to ED because of diagnostic ambiguity. While the procedure in question may be "elective", the patient's clinical status may be complex, necessitating more comprehensive assessment. Other factors may include geographical challenges, which limit the ability to manage patients in communities without referrals to ED even for more elective procedures (e.g., remote rural communities). Moreover, even though patients may not be acutely ill, they may be sufficiently symptomatic and in need of temporizing or definitive surgical management for quality of life issues. Furthermore, not all elective procedures are similar; not all procedures have uniform "elective" definitions.

Some physicians may feel that utilizing the ED for non-urgent procedures may be justified in selected cases. Let us examine the extreme hypothetical example of an in-grown toe nail. Most would contend that in-grown toe nails constitute "elective" rather than "urgent procedures" (should a procedure be needed at all). Yet, questions still remain. Might there ever be a circumstance whereby in-grown toe nails require more timely intervention (e.g,. infection)? What degree of symptoms would justify an in-grown toe nail from being managed in the ED? Finally, what if patients themselves advocate for ED or expedited services? In such circumstances, physicians may feel obliged to refer patients to the ED. In our study of preferential access discussed in question 1, physicians acknowledged that patient pressure was a driver or determinant of preferential access, in that physicians were responding to patient pressure.

Physicians

Responding to requests to see patients in their office quickly by slotting them in before or after normal office hours or on the weekends

This depends upon the physician's usual practice schedule and the clinical circumstances of the patient. Physicians usually have flexibility in their schedules to "slot" patients in on a case-by-case basis. Such decisions are entirely discretionary and left up to the physician. If a patient is sick and is in need of medical attention, then the opening up of slots would not be considered "preferential access" because in such circumstances, expedited access is being provided in accordance to

clinical necessity. If the "opening up of slots" were done selectively based on personal connection (e.g., family members, friends, VIPs, or others of influence), then such scenarios would be considered examples of preferential access. However, if care were still appropriate, then, as discussed elsewhere, such circumstances would in my opinion represent examples of "proper" preferential access. "Proper", in that care was still medically justified at some level.

Physicians writing prescriptions or providing medical care for friends, family or colleagues outside of their medical office

This represents preferential access. It is only "proper" if the prescriptions themselves reflect appropriate management. Physicians who write prescriptions for family, friends or colleagues outside of their medical office may not have had the time, medical equipment, or the ability to objectively diagnose or evaluate clinical conditions accurately or appropriately. In such circumstances, prescribing medications can be inappropriate (if not dangerous), and might accordingly exemplify "improper" preferential access. The assessment of written prescriptions also depends on the management in question. For example, prescribing a family member or friend an antibiotic in response to a rapid-positive strep screen for throat infections is very different than prescribing a family member or friend narcotics or benzodiazepines.

Private Health Care Facilities

Do membership based private health care facilities constitute an example of preferential access?

Yes. These would often constitute third-party payer (e.g., employer/insurance) health care. Where legal, these would in my opinion, exemplify proper preferential access.

MLAs or their Staff

Providing advice to their constituents about wait times, alternate care options etc.

No. Every patient should be given advice about wait-times and alternate care options. Where available, such information is often publicly accessible. Patients themselves should seek-out such information. Accordingly, providing advice about wait times or

alternate care options does not in my opinion exemplify preferential access, unless, such information was not otherwise publicly accessible.

Requesting special consideration for a constituent by communicating directly with a health care provider

This depends upon the usual practice style of the physician. In theory, most physicians may do this routinely for their patients irrespective of personal connections or VIP status of the patient. Where physicians reserve such communication only to patients for whom there is a personal connection/VIP status, then this would be considered preferential access. If the special consideration is medically justifiable, then it is an example of "proper" preferential access.

Senior Hospital or Health Authority Officials

Requesting special arrangements (eg: private room, anonymity etc.) for a VIP or high profile patient

In my opinion, this would constitute "proper" preferential access. Anonymity may be important for a variety of reasons (confidentiality, distraction, etc.). Moreover, there are already precedents whereby private rooms are covered under third-party or first-party parallel private plans (e.g., Blue Cross). Finally, neither private rooms nor anonymity directly impacts on medical care per se (although, as discussed elsewhere, access to medical care will generally be more expedient as well).

Calling front line staff to make them "aware" that a VIP patient is in the hospital or in the system

I think this would exemplify preferential access. Given that these are front line staff, they are likely involved directly in the management of patients. "Awareness" among such staff, may (and almost certainly will) have effects on the evaluation and management of such patients. These circumstances would exemplify "proper" preferential access as long as the care being provided to the VIP is appropriate, and the outcomes of non-VIP patients are not being adversely affected by the expeditious care being provided to the VIP.

6. Are you aware of any safeguards which currently exist in the health care system to prevent "improper" preferential access?

Aside from the legal implications associated with improper payments, system safeguards to prevent improper preferential access would be three-fold: (a) ensuring that access to a service in question does not become too constrained that it cannot deal with the realistic pushes/pulls that are to exist and remain in society. Ensuring sufficient capacity will not eliminate or prevent preferential access. However, it will ensure that those in need can still receive services when preferential access does occur. (b) Explicit management systems that prioritize patients according to clinical necessity. Currently, there are rare examples of services (e.g., bypass surgery waiting lists in Ontario) that assign recommended waiting times in accordance to clinical severity. The broader implementation of explicit waiting-list management systems/formalized queues could not only help prioritize patients in accordance to clinical need, but could also facilitate system tracking and surveillance of waiting-times and outcomes, to ensure that those individuals in need are receiving service without excessive delays. (c) Demand-side initiatives that discourage the utilization of services that are not required based on appropriateness criteria. These admittedly are harder to implement. However, the assignment of appropriateness criteria/indications when patients are referred for services will at the very least allow for better system tracking.

i) If so, do you believe such safeguards to be effective and why?

The goal here would not necessarily be one designed to eliminate or prevent preferential access for the sake of equity. But rather, to prevent or mitigate adverse outcomes resulting from excessive waiting-time delays. Ensuring that there is sufficient supply/capacity for service, ensuring that there are recommended maximum waiting-times that are assigned based on clinical need, and ensuring that referrals for service are justifiable based on appropriateness criteria will minimize or manage the adverse consequences that may arise as a result of preferential access. System monitoring and tracking will ensure that no patient is waiting excessively for service.

7. Do you believe that there are changes that can be made to the existing health care system to avoid or prevent "improper" preferential access?

Yes. Discussed above.

What changes would you recommend and why?

As discussed above. I view this as a system management issue more so than a societal ethical issue. Preferential access will occur. It is a reality. As with other programs in society, health care is multi-tiered. While health equity is a goal in our society, I don't believe Medicare is predicated on access equity. Regional inequalities in the distribution of services will create different access opportunities for different individuals. Interpersonal relationships and other societal values (that aren't necessarily predicated on egalitarianism) will filter into health care delivery. Clinical symptoms may be experienced and/or perceived differently between individuals. Inequities and inequalities will exist; such are the realities in Canada. The goals therefore are to ensure that the system can handle such inequalities to mitigate the repercussions and consequences of access inequalities on the health and outcomes of individuals in Canada. Supply-side initiatives, demand-side initiatives, and formalized waiting-list management systems will help safe-guard against adverse effects in the queue by ensuring timely access to services in accordance to patient need, regardless of whether some get serviced quicker than others.

(d) Responses to Expert Questions

Dr. Brian Goldman

1. What is "preferential access" to health care?

i) Is there a common definition?

This is a crucial question to the Inquiry. From my examination of the medical literature plus my recollections of conversations with mentors and colleagues over more than thirty years, I am not aware of a common definition. Looking at the medical literature, the common elements to the definition include preferred access to and utilization of medical services for different patients of equivalent medical need based on factors other than medical need.

In my view, preferential access may be deliberate; or may be due not to deliberate intent but to observational factors. Such factors include age, sex, education and socioeconomic background.

For example, in a prospective observational cohort study of more than two thousand patients with acute myocardial infarction admitted to fifty-three hospitals across Ontario, Alter and colleagues found that more affluent or better educated patients were more likely to undergo coronary angiography, receive cardiac rehabilitation, or be followed up by a cardiologist than were patients in lower socioeconomic strata.

In my opinion, since it is not considered intentional, preferential access of this sort has been studied extensively. With preferential access or queue-jumping by design or intent, this is not the case. This is reflected in the number of citations on PubMed. Using the search terms 'preferential access' and 'health care', I found seventy-two articles; using the search terms 'queue jumping' and 'health care', I found just three articles.

In an article entitled 'Ethics in Radiology: Wait Lists Queue Jumping', Cunningham and colleagues write: "At present, there are few resources available to Canadian radiologists and radiology training programs to facilitate this learning."

In their survey on queue jumping published in 2007 in the European Journal of Emergency Medicine, Friedman and colleagues defined

queue jumping as the provision of preferential access to medical care for reasons other than medical need.

To my knowledge, the above definition has not been accepted widely. I would suggest that there is no universally recognized definition for the deliberate provision of preferential access based on factors other than medical need because such activity is considered unethical because it offends the concept of social justice.

In blog entry entitled 'Queue Jumping, Standards of Practice and Budgets', Dr. Trevor Theman, Registrar of the College of Physicians and Surgeons of Alberta, incorporated many of the elements of a formal definition of preferential access when he wrote the following:

> It calls into question the whole notion of queue jumping and its definition, and the very real question of what definition will the inquiry accept and use. I note that the Cabinet order creating this inquiry states, in the preamble, that access to publicly funded health services is properly based on patient need and the relative acuity of a patient's condition and that it is improper to gain access to publicly funded health services through threat, influence or favour.

In my opinion, the inquiry would do well to establish a definition of queue jumping that encompasses the following dimensions:

- Preferential access to publicly funded services;
- Based on factors other than medical need (for example, overt reward such as money, power, or influence or expectation of same);
- Offends the principle of social justice by correspondingly delaying or denying access to another individual of equal or perhaps even greater medical need.

2. Is there a difference between "proper preferential access" and "improper preferential access"?

In my opinion, the distinction is open to considerable variations in interpretation. In medicine, there is universal acceptance of the notion of preferential access based on medical need. There are many tangible examples of this in medicine. For instance, in emergency medicine,

using the Canadian Triage Acuity Scale (CTAS), patients are triaged into one of five categories based on the acuity of their illness or injury and the immediacy of the threat to life or limb. These are arranged in descending order of medical need. CTAS Level 1 patients – examples include Cardiac/Respiratory arrest, major trauma, and shock states – need to be seen immediately, regardless of when they arrive in the ED. CTAS Level 2 patients – examples include those with altered mental status, head injuries, severe trauma, heart attacks – need to be seen within 15 minutes of arrival. By contrast, CTAS Level 5 patients – examples include sore throat, upper respiratory infection and mild abdominal pain – need to be seen within 120 minutes eighty per cent of the time.

I would define proper preferential access as that provided based on legitimate medical need. I would define improper preferential access as that occurs by intent of the patient or an individual who arranges that access on the patient's behalf or because of passive factors discussed above (e.g. age, gender, level of education, social status, and the knowledge and experience of the patient's care providers).

3. In your opinion, what would be examples of "proper" preferential access to health care?

Examples of "proper" preferential access to health care include:

- immediate access to angioplasty or bypass to patients with acute coronary syndrome;
- organ transplant access in order of need based on consensus criteria;
- priority assessment in the ED of agitated patients out of concern for the disruptive effect of such patients on work flow and emergency personnel;
- separation of ED patients into major, ambulatory and rapid assessment zone (RAZ) categories so as to improve overall efficiency and throughput.

Is there harm to the public care system associated with "proper" preferential access to health care?

Of course there is. In general, preferential access operates on a 'one patient at a time' basis and with little if any regard for the impact of said access on the integrity of the system. The fact that there are wait times for everything from MRIs to joint replacement therapy demonstrates the potential for adverse effect on the system. In terms of patients requiring extraordinary levels of care, right now, the system can tolerate one patient at a time requiring thrombolytic therapy for a stroke or a ventilator for a patient with an exacerbation of chronic obstructive pulmonary disease. However, a large number of patients requiring these services can quickly overwhelm the system. It is for this reasons that notions of medical futility (the provision of life prolonging treatment without hope of returning the patient to a reasonable quality of life) are gaining attention in any discussion of the future of publicly-funded health care. The coming 'boomer tsunami' will likely test the system's ability to provide "proper" preferential access.

In your opinion, what is the nature of that harm?

There are two kinds of harm. The first is direct harm to patients who have to wait longer for treatment because of others who are deemed to have preferential access because of a legitimate need as currently defined. Patients who don't meet the test of "proper" preferential access wait longer and as a result suffer reduced quality of life if not an overt threat to their health. The second type of harm is to the system. The more patients needing "proper" preferential access, the less predictable the demands upon the system and therefore the less efficiently it runs.

Is that harm acceptable from an ethical or practical perspective?

From a practical perspective, the harm described above is acceptable because a publicly funded system does not possess infinite resources and therefore cannot be all things to all people at all times. From an ethical perspective, it can be argued that the harm caused by "proper" preferential access is not acceptable. In 2010, I hosted a town hall meeting at George Street United Church in which bioethicists Dr. Lionel

Rubinoff mused about an emerging concept among bioethicists. Notions of patient autonomy tend to predominate discussions of whether or not to offer life-prolonging or death-delaying treatments. Rubinoff said that as members of society, patients must balance autonomy with justice. He said bioethicists are beginning to discuss the idea that patients should have a duty to refuse death-delaying treatments that are widely considered to be futile, especially in tough economic times in which resources are finite.

4. In your opinion, what would be examples of "improper" preferential access to health care?

- Any instance in which a health care provider or employee with access to the booking system for health services gives preferential access to a publicly-funded health care service in return for a payment of cash or gifts.
- Any instance in which a health care provider or employee with access to the booking system for health care barters preferential access to publicly-funded health care in return for services and/or discounts.
- Any instances in which a 'VIP' receives preferential access to publicly-funded health care for no reason other than the fact they are famous.
- Any instance in which a health care provider or employee with access to the booking system for health care services offers a 'VIP' preferential access to publicly-funded health care services in return for the possibility of receiving a favour or favours at some point in the future.
- Exception: In my opinion a VIP who provides major support to a particular health facility should obtain preferential access to publicly-funded health care services provided by that facility because a) his or her financial support provides a net benefit to the health care system and b) it would be petty and churlish not to provide such services in that situation.

i) Is there harm to the public health care system associated with "improper" preferential access to health care?

Yes.

ii) In your opinion, what is the nature of that harm?

Improper access harms patients treated in a publicly-funded health care system by lengthening wait lists. Improper access harms the system by reducing efficiency, by undermining public confidence in a publicly-funded system and by reinforcing such behaviour.

iii) Is that harm acceptable from an ethical or practical perspective?

From an ethical perspective, improper access is unacceptable because it offends the true purpose of publicly-funded health care, which is to provide health care to the public regardless of ability to pay. Permitting wealthy and individual patients to obtain improper preferential access turns access to decision making in health care into a commodity that can be sold or bartered to the highest bidder. Improper access to publicly-funded health care undermines the concept of social justice and also undermines social cohesiveness. Left unchecked, it can lead directly to evolution of publicly-funded health care into a two-tiered system. From a practical perspective, improper access is unacceptable if it reduces access to the system by patients who do not use or have recourse to improper means. That results in longer wait times which can lead to greater morbidity which in turn puts even greater stress on the system.

5. Which of the following would you characterize as "proper" or "improper" access to health care and why?

Physician advocacy?

In my opinion, physician advocacy is an example of "proper" access to health care. Advocacy can be patient-centred, clinical, administrative or legislative. Advocacy is considered a core value of the practice of medicine. There are calls for advocacy training in medical education. Advocacy based on

evidence is always proper. Advocacy that is based on emotion rather than evidence may lead to improper access. The phrase "the squeaky wheel gets the grease" comes immediately to mind. However, in this case, the fault lies not with the physician advocate but rather the system that permits advocacy without evidence-based merit.

Physician use of emergency OR slots to book patients for surgeries?

If such a practice necessitates postponing emergent cases, then such access would be improper. However, if it's a case of "use it or lose it", then one can argue that such a practice while not proper makes appropriate use of the system based upon the administrative context.

Allowing a physician or hospital worker to obtain an MRI faster than spending time on the waiting list?

This is the Canadian equivalent of "professional courtesy". In countries such as the United States – where health care is an out of pocket expense – professional courtesy generally refers to the provision of medical services free of charge or at reduced rates. As recently as 1993, surveys indicated that almost all American physicians extended professional courtesy to colleagues. Although not formally defined as such, professional courtesy in Canada has come to mean physicians and other health professionals offering preferred or faster access to medical services than the lay public would ordinarily receive. It would be up to the inquiry in Alberta to decide whether such assess is improper or not. Some consider it improper. Others say such preferred access is proper for two reasons. First, it alleviates the added apprehension of health care workers given their knowledge of the worst case scenarios of presenting complaints. Second, the faster a health care worker is seen and treated, the faster that worker can return to productive work, which is a net benefit to the health care system. The argument often stated anecdotally by health professionals – "in a publicly-funded system, faster access is the only thing we can offer each other" – is based on emotion and tribalism and is clearly an example of improper access. It

would be well worthwhile to do a survey to determine the scale of professional courtesy in Canada.

Hospital or medical staff obtaining flu shots before the general public?

This is clearly an example of "proper" access to health care. Studies have shown that higher rates of immunization among health professionals lead to lower rates of flu and lower rates of mortality among residents of long term care facilities and lower rates of flu transmission in hospital. It also leads to lower rates of absenteeism in the health care system. For all of these reasons, preferred access to flu shots is a net benefit to the health care system.

Professional athletes and their families obtaining flu shots or medical treatment before the general public?

This is clearly an example of "improper" access to health care. There is no net benefit to the health care system or the public from such a practice. If allowing it to occur inconveniences or delays other patients, then one can argue the practice is unethical.

A physician arranging for a friend or family member to be seen quickly?

This is an example of "improper" access because doing so clearly causes others with illnesses of equal or even greater severity to wait longer simply because they have no such advantage.

Politicians/donors/philanthropists being seen in emergency without waiting (depending on the nature of the problem)?

This is clearly an example of "improper" access because it confers advantageous access based on fame, power or money. As I said above, one could make an exception for donors if their contributions provide a net benefit to the health care system.

Additional Scenarios

In your opinion, would you characterize the following examples of access to care as:

- ***Preferential access or not preferential access;***
- ***If you determine it to be preferential, is it "proper" or "improper?"***

Please explain, briefly, the reasoning behind your opinion.

Emergency Department Care

- **Providing high profile people with a separate waiting area away from the general public.**

 This is an example of improper preferential access because in a single payer publicly funded system, access to ED services of any kind should be based solely on medical need. Although a separate waiting area per se would not necessarily convey superior treatment, such an entity would undermine social justice by creating a perception that by being in a separate waiting area, high profile people would receive preferential access.

- **Providing priority access to care for doctors, nurses or AHS staff and/or family members accompanied by doctors, nurses or AHS staff.**

 This is clearly an example preferential access. The issue is whether or not it is improper. In the United States, where medical services are not free of charge, there is a long and unchallenged tradition of professional courtesy in which colleagues receive care free of charge or at reduced rate. Given the long tradition of professional courtesy, in my opinion, it would be churlish to deny physicians the right to provide special access to colleagues they work with and esteemed colleagues in the medical community at large. One can argue that there is a net benefit to society if such preferential access results in a colleague returning to work faster. However, this would be of no relevance in the case of

retired colleagues. In my opinion, the same courtesy should be extended to immediate family members of the colleague. Although this opinion may offend some and may be tacit approval of a social injustice, in my opinion, we must create rules that take human nature into account. For example, my father has been admitted to the hospital where I work on three occasions in the past two years. The staff that have cared for my father were unfailingly courteous and helpful to him and to me. I have no doubt the fact I am a colleague played a role in this. Were that courtesy to change to an attitude of contempt or condescension (as in "You know the rules, Brian. Fair is fair."), it would probably affect my ongoing relationship with those colleagues.

- **Physicians asking their own patients to go to the ED to receive elective procedures.**

 This is a grey area. The answer depends on how ill the patient is. If by elective, you mean that the need for the procedure is in no way an emergency, then asking the patient to go to the ED to receive it sooner is an example of improper preferential access because it's gaming the system – knowing that ED staff are largely unable for medical legal reasons to declare a patient a non-emergency and send them home. What makes this a grey area is that all too often, the patient sent to the ED to have a test or a procedure done sooner needs it sooner. Looked at another way, studies show that people who come to the ED need care. Very few ED visits are out and out unnecessary. The larger issue in this instance is that often, the larger problem is lack of comprehensive primary care – which necessitates ED visits for care that should be available elsewhere.

Physicians

- **Responding to requests to see patients in their office quickly by slotting them in before or after normal office hours or on the weekends.**

 This is not preferential access unless the practice is used on a habitual basis to funnel preferred access patients into the

system. The answer therefore depends on the circumstances. I have met many consultants who make room to see an urgent referral by seeing them in off hours. As well, one could argue that the consultant who sees patients in their office quickly by slotting them into off hours is preserving the integrity of the system by not slotting such patients into normal working hours. Physicians must retain the option to manage their own time.

- **Physicians writing prescriptions or providing medical care for friends, family or colleagues outside of their medical office.**

 The writing of prescriptions and the providing of medical care for immediate family members outside of emergencies is a form of conduct that is governed by specific provisions of regulated health professions legislation. If prescribing under such circumstances is considered improper, then it is my view that there is no need to give an opinion as to proper or improper preferential access. The providing of prescriptions and medical care for friends and colleagues is likely a form of preferential access since it is less likely to be made available to patients who are neither friends nor colleagues. However, in my opinion, there is not enough information provided in the premise to this section to judge whether such preferential access is proper or improper.

Private Health Care Facilities

- **Do membership based private health care facilities constitute an example of preferential access?**

 Such memberships likely provide preferential access. One could argue that such preferential access is proper since it is limited to non-insured services such as massage therapy and access to a registered dietician. However, from interviews that I did for a radio show on concierge medicine, it's clear to me that part of the service provided by the physician in return for a membership includes privileged access to the physician via phone or email during out of office hours. If the physician has completely opted out of provincial Medicare, then such access

would be considered neither preferential nor improper. However, were the physician to bill both the patient and the province, doing both would in my opinion blur the boundaries between public and private services. As such, it would be highly likely that at some point in the course of care, the patient would be receiving improper preferential access.

MLAs or their Staff

- **Providing advice to their constituents about wait times, alternate care options etc.**

 The answer depends on how they get the information they share. If the information were available freely, then such a practice would not be preferential and would in any case be proper.

- **Requesting special consideration for a constituent by communicating directly with a health care provider.**

 In my opinion, such requests are what MLAs do on behalf of their constituents, and are neither preferential nor improper. That said, if a health minister or a legislative secretary with direct responsibility for health care were to do the same thing, in my opinion, doing so would, if successful, lead to improper preferential access. This is because the person being asked to provide special consideration might reasonably consider the request an order with consequences if disobeyed.

Senior Hospital or Health Authority Officials

- **Requesting special arrangements (e.g. private room, anonymity etc.) for a VIP or high profile patient.**

 If successful, this would certainly be an example of preferential access that would in my opinion be improper. This is because the person being asked to provide special consideration might reasonably consider the request an order with consequences if disobeyed.

- **Calling front line staff to make them "aware" that a VIP patient is in the hospital or in the system.**
 In my opinion, this form of communication is the same as an out and out request, since the person receiving the call would in all likelihood understand that the purpose of the call is to make certain the VIP patient receives preferential access. If that were the only deciding factor, then the preferential access would be improper because it would in all likelihood bump a more medically deserving patient down the list.

6. Are you aware of any safeguards which currently exist in the health care system to prevent "improper" preferential access?

I'm not aware of any such safeguards. Given the ready acceptance of the advocacy role of physicians, it would be very difficult to tease out improper from proper advocacy without asking the advocate a lot of intrusive questions.

7. Do you believe that there are changes that can be made to the existing health care system to avoid or prevent "improper" preferential access?

It should be possible to discourage "improper" access through educational campaigns aimed at the general public and the health professions. Such a campaign could utilize radio, television and print ads to demonstrate examples of improper access and to discourage the practice.

System changes could also be put into place to discourage health care providers from trying to game the system. For example, placing an explicit message discouraging "improper" access on a diagnostic imaging order form or request for consultation may be effective. Putting in place a system to screen out attempts to obtain "improper" access might also be effective.

The main caveat of such initiatives is that their success may only be short-lived.

(e) Response to List of Questions to be Answered by Experts

Pam Whitnack

1. What is 'preferential access' to health care?

Dictionaries define 'preferential' as giving advantage or a priority. Hence, 'preferential access' would describe a situation where an individual is given advantage or a priority in access to health care services.

There are a variety of definitions of the term 'preferential access'.

It is often described as queue jumping where an individual receives the service more quickly than others on a waiting list. However, some would consider preferential access to describe an advantage available due to geographic proximity or economic circumstance. Other considerations are factors such as ethnic diversity, language barriers and gender inequality. Services provided to Workers' Compensation Board clients and uniformed groups such as the RCMP may also be considered preferential.

The issue most commonly arises with respect to access to scarce resources.

2. Is there a difference between 'proper preferential access' and 'improper preferential access'?

The term proper 'preferential access' may be used to describe preference given on the basis of clinical need or urgency. Medical judgment is the basis used to establish this priority.

'Improper preferential access' describes priority given to an individual with less clinical need because of some other action such as a financial incentive, or the exertion of influence, threat or offer of a favour.

3. In your opinion, what would be examples of 'proper preferential access' to health care?

'Proper preferential access' is appropriate treatment of individuals with greater clinical need. Geographic location provides an advantage of quicker access to some services, however this is largely unavoidable.

i) Is there harm to the public health care system associated with 'proper' preferential access to health care?

There may be harm, in that it is impossible to assess the relative clinical need of individuals across a system with so many patients, providers and range of assessment skill. In a complex system, it is likely to be imperfect.

ii) In your opinion, what is that nature of that harm?

Harm would result in the impact on other individuals waiting for service. Even though their clinical need may not be as great at the time, their condition may deteriorate while waiting longer for service. This impacts not only the suffering of the individual, but also potentially the acuity and resource impact of their eventual treatment.

With respect to geographic advantage, some rural areas have potentially greater access to basic and primary care services, yet may be disadvantaged with respect to their access to tertiary services.

iii) Is that harm acceptable from an ethical or practical perspective?

While the harm associated with 'proper preferential access' may not be acceptable from an ethical perspective, from a practical perspective, solutions bring into question the allocation of scarce resources.

4. In your opinion, what would be examples of 'improper preferential access' to health care?

Examples of 'improper preferential access' to health care would include: payment made to a provider in an effort to receive a service more quickly; providing service to a friend without regard to the urgency; providing service more quickly because of the public profile of the individual.

i) Is there harm to the public health care system associated with 'improper' preferential access to health care?

The harm to the system arises in that all individuals are not treated equally. Those that may have a greater clinical need have their treatment delayed in favour of someone with a greater advantage.

However, how can the system adjudicate given the complexity of the system? Specialist physicians and services have varying waitlists. This combined with different assessment skills and clinical judgment may cause individuals to seek a second opinion from a service with a shorter waiting list. Is this 'improper' preferential access if the clinical need exists? Because resources for many services are scarce, individuals try to navigate the system by whatever means are available to them.

ii) In your opinion, what is the nature of that harm?

The risk to the health of an individual with greater need is the harm.

While waiting longer than necessary, health can deteriorate, sometimes with drastic consequences.

iii) Is that harm acceptable from an ethical or practical perspective?

The harm is not acceptable from an ethical perspective as the system has an obligation to offer service to those most in need. From a practical perspective, delayed service may mean that an individual requires a higher level of service than they may otherwise require if treated more promptly.

5. In your opinion, would you characterize the following examples as 'proper' or 'improper access' to health care? [Explain with reasons where applicable]

i) Physician advocacy? Is this a good thing? Why or why not?

It is quite appropriate for physicians to advocate for their patients if the basis for the advocacy is clinical need. However, there is always the possibility this advocacy may be interpreted as a means to influence resource allocation within the health care system. Examples of clinical

need can include need to shorten wait lists for cancer surgery or to establish a colonoscopy program. In these circumstances, the physician is advocating for a program to serve a group of patients to the benefit of many individuals. Other examples though, may be advocacy to establish a program in a location that may not have the necessary supports from a quality and safety perspective, yet the physician advocates for the program on the basis of improving access generally. This latter situation can result in inefficient allocation of resources.

ii) Physician use of emergency OR slots to book patients in for surgeries?

The issue in this example is the appropriate use of OR time. Emergency slots should be used for emergencies. If the time slots are unused by emergencies, it is appropriate for the physician to use those times to treat his patients with the highest clinical need. This raises the question of course, about how one would actually have those patients available for surgery! Physicians understandably wish to make the best use of the available OR time. It is very difficult to assess the relative clinical need of the patients and thus very difficult to define as 'improper' preferential access.

iii) Allowing a physician or hospital worker to obtain an MRI faster than spending time on a waiting list?

In my opinion, this is an example of 'improper preferential access' if it is planned. However, there are occasions when patients who are booked for procedures cancel their bookings or do not show. On those occasions, what is the process? Does the department try to contact people on the wait list to come in on short notice? Or, is it more convenient to call a health care worker or physician who needs the procedure because of their proximity? I believe the high cost equipment should be used most efficiently, however every effort should be made to fill gaps created by cancellations from the priority waiting list.

iv) Hospital or medical staff obtaining flu shots before the general public?

In my opinion, this is 'proper preferential access'. The health of the public is best protected through immunization of caregivers so they do not adversely affect the health of others.

v) Professional athletes and their families obtaining flu shots or medical treatment before the general public?

My view is this is an example of 'improper' access to health care. There is no reason for this group to receive service ahead of the general public. There may be an economic benefit to society if professional athletes are able to play their sport, but there is no clinical reason for this to occur.

vi) A physician arranging for a friend or family member to be seen quickly?

In my opinion, this is 'improper preferential access'. This example implies the friend or family member requires access to specialty services of some sort. The clinical need may be very high, yet ethically, the individual should follow the same path as others who are competing for access to scarce resources.

However, if waiting lists were reduced, the physician would not be called upon to respond to these requests with the same frequency.

This example is very difficult to assess since the person who the physician is assisting may have a high clinical need. The physician may be a skilled navigator of the system, but that does not negate the possible urgency of the friend or family member's condition.

vii) Politicians/donors/philanthropists being seen in emergency without waiting (depending on the nature of the problem)?

Emergency departments have a triage system that should be used for all patients regardless of social status. However, there may be a need to provide extra supports to ensure confidentiality for higher profile individuals.

6. Are you aware of any safeguards which currently exist in the health care system to prevent 'improper preferential access' effective?

i) If so, do you believe such safeguards to be effective and why?

I am not aware of any documented safeguards. There was a request by the CEO of Alberta Health Services for staff to refer any requests for preferential access to him. This was effective in providing staff with a buffer and allows requests to be considered at a higher administrative level.

7. Do you believe that there are changes that can be made to the existing health care system to avoid or prevent improper preferential access?

i) What changes would you recommend and why?

It is very difficult to establish specific rules and processes in a complex system that relies heavily on clinical judgment as the 'gatekeeper' for access. Creation of another bureaucratic process is unlikely to help.

Perhaps consideration can be given to strengthening the values and policies within the system. Greater awareness of the importance of universal access based on clinical need would provide reassurance to the public as well as reinforcement for providers to avoid circumstances that create 'improper' preferential access.

The Government of Alberta has introduced Bill 4, *The Public Interest Disclosure (Whistleblower Protection) Act* to the legislature. Though it will apply to the public service including Alberta Health Services and is expected to be enacted next spring, I am uncertain if this will apply to cases of 'improper' preferential access, but it does refer to situations of gross mismanagement of funds or acts that pose a danger to the public or the environment. Again, the system does not need to be encumbered by lengthy investigative processes, yet this existence of a deterrent may be helpful.

Addendum to Question #5:

In your opinion, would you characterize the following examples of access to care as:

- ***Preferential access or not preferential access;***
- ***If you determine it to be preferential, is it "proper" or "improper"?***

Please explain, briefly, the reasoning behind your opinion.

Emergency Department Care

Providing high profile people with a separate waiting area away from the general public

Provision of a separate waiting area is not preferential access, it is a means to protect the privacy and confidentiality for the individual. This would be preferential if the person receives treatment ahead of another with less need; or if another person who does not have a high profile were displaced from the available private space to accommodate the 'VIP'.

Providing priority access to care for doctors, nurses or AHS staff and/or family members accompanied by doctors, nurses or AHS staff

Priority of access should be based on clinical need. Just because someone is a doctor, nurse or AHS staff or accompanied by them does not mean that their clinical condition is not urgent. However, if they are treated with a higher priority than someone of less clinical need, then this is an example of 'improper preferential access'.

Physicians asking their patients to go to the ED to receive elective procedures

If the patient is sent to the ED to circumvent another scheduling process, then this may be an example of 'improper preferential access' as the example speaks of an elective procedure. However, there may be some reason that the physician believes there is a degree of urgency for the procedure that warrants a process other than traditional access. This again raises the question of fair means to adjudicate.

Physicians

Responding to requests to see patients in their office quickly by slotting them in before or after normal office hours or on the weekends

A physician is responsible for the management of their own office practice. If they choose to see patients during extended hours, that is their choice. Presumably, they would be making those decisions based on the urgency of the patient's condition, and would not be 'improper' access.

Physicians writing prescriptions or providing medical care for friends, family or colleagues outside of their medical office

Physicians practice in accordance with Code of Ethics and Guidelines as set out by the College of Physicians and Surgeons. This would provide the framework for treating individuals with whom they may have a personal relationship. Within that framework, if a physician chooses to write prescriptions or provide medical care outside of their office, they would make the decision with respect to the clinical need and act accordingly. In some cases this may constitute improper access, but is difficult to adjudicate.

Private Health Care Facilities

Do membership based private health care facilities constitute an example of preferential access?

This depends on the benefits provided through membership. If I am promised an appointment the same day, this is available through the public system in many physician practices, so there is nothing preferential.

If I have paid for a membership that provides me with fast access to a private MRI when needed as part of my 'benefits', then I am not impacting the public system. This is no different than my ability to pay for a private MRI without the benefit of membership.

However, if I am promised faster access to publically funded services where I am placed in the queue ahead of someone with greater clinical need, then this is an example of improper preferential access.

MLAs or their Staff

Providing advice to their constituents about wait times, alternate care options etc.

The health system is large, complex and difficult for many people to navigate. It is not improper for MLAs or their staff to provide information and advice to their constituents.

Requesting special consideration for a constituent by communicating directly with a health care provider

The MLA or their staff may wish to advocate on behalf of an individual based on perceived need. However, it is very difficult for any lay person to assess clinical need. Requests should not be made to front line staff, as this may be perceived as the MLA exerting influence or an attempt to gain preferential access for the constituent. The current position of AHS is such requests are referred to the CEO for consideration.

Senior Hospital or Health Authority Officials

Requesting special arrangements (eg: private room, anonymity etc.) for a VIP or high profile patient

All individuals have the right to expect their privacy and confidentiality will be maintained. Every effort should be made to provide this protection for VIPs, high profile individuals and their families.

A means to avoid special requests from senior hospital or health authority officials may be to provide staff in the ED with a policy or guideline that outlines what is expected in such a situation. Situations may arise where no private space is available, or it is occupied by a person with higher clinical need. In these cases, it may be impossible to provide the additional privacy to the VIP or high profile individual.

That said, it does not mean that the VIP or high profile individual should receive faster treatment, but rather a private place to wait in the queue. Faster treatment would be an example of improper preferential access.

Calling front line staff to make them 'aware' that a VIP patient is in the hospital or in the system

This is not an example of preferential access unless there is an expectation of some special treatment.

(f) Response to Questions of Access

Dr. Owen Heisler

What is "preferential access" to health care? Is there a common definition?

There is no common definition not just of preferential access but health care itself. If we consider health in its proper perspective (as per the World Health Organization) health extends beyond disease management to the wider social and spiritual aspects of health. Just as hospitals and physicians are important to health care, of equal if not greater importance are housing and income disparities within society. Such discussion is beyond what is under consideration here which I will take to be the health care system that is funded through the Alberta Government Department of Health. The concept of access is layered on this definition as the nature of both the system itself and the access to said system are extremely complex, layered in culture, politics, history and societal paradigms reflecting the social contract that exists in Canada.

Governments generate revenue through taxation. They utilize this global revenue to provide services for individual members of their society. There is a limit to how much is available for public goods corresponding to decisions on, and societal tolerance for, taxation levels. Not everyone who pays into the 'system' receives access to the entire scope of care they might desire. Not everyone who benefits from services contributes financially to the revenue base funding services. Different societies have different levels of taxation, different levels of government involvement in providing public goods and different value laden strategies in making decisions about allocation of public funds. Decisions on allocation of the public purse are expected by the public and the press to be made in a manner consistent with the ethical framework of the population providing the resources. Given resources are scarce (or there would be no need for allocation), those making the decisions will be held to task by the public for the choices they made as when allocating resources to one stakeholder group there will invariably be other groups who receive less than they wanted – the opportunity cost.

For resource allocation one usually considers three different kinds of allocation – macro, meso and micro. The macro allocation issue would

be the larger issues faced by government in deciding how much of their global budget goes to 'health' compared to 'education' for example. These are global overarching decisions. Macro allocation decisions in Canada tend towards a modified egalitarian approach elevating health care to a basic right as opposed to the libertarian approach in the United States that considers health care more a commodity (see Appendix A). The meso allocation issues are those 'in between' decisions and are often hospital or region based. An example of a meso allocation issue would be whether a hospital with a given global allocation of resources (macro allocation already done) chose to spend its limited resources on a new orthopedic program or an integrated medical-surgical program for obesity. On a meso level, balancing acute health care interventions and preventative strategies is a pressing challenge in a resource limited environment. The decision as to which individual gets the hip operation within the orthopedic program would be a micro allocation issue. It would appear from the questions that have been proposed it is these micro allocation decisions which are the primary focus of this inquiry and further comments will concentrate on these decisions.

The questions that are being asked in this inquiry are framed as what is 'proper' or 'improper', what is 'right' and 'wrong' in regards to health care access – the subject of normative ethics. These micro allocation questions mean we must touch on the normative ethical paradigms of health care delivery in the Canadian context (see Appendix B). The challenge is when individuals say something is 'ethically' or 'morally' right this typically relates to their own unique perspective (most often shared within their local culture) which itself is often inconsistent as it is not unusual for individuals to flip flop on paradigms. As new technologies develop we see an increasing (apparently insatiable) demand fast outstripping society's ability to provide. This is reflected by increasing wait times and queues for limited resources. The question becomes how to allocate resources not just for individuals but, more importantly, to prevent implosion of the system for the entire society. Equality for everyone (egalitarianism) versus rule oriented distribution (libertarianism) and rights versus obligations become topics of hot debate. Conflicts arise. What is the right balance between advocating for individual patients and advocating for the rights of an entire population and which paradigm should be used?

Physicians in the Canadian environment are a group that deserve special attention given that it has been estimated that 70% of the health care costs can be directly traced back to a decision made or influenced

by a physician. Appealing to 'professionalism' as a reason for physicians to participate in allocation decisions does not recognize the paradigm conflict between their fiduciary responsibilities and managing population needs. The challenge is that professionalism, if not the classical fiduciary physician-patient relationship, is, like health care itself, also not clearly defined (see Appendix B).

Is there a difference between "proper preferential access" and "improper preferential access"?

When resources are limited there should ideally be a well-defined, agreed upon, transparent algorithm outlining strategies as to how resources (both rights and obligations) should be shared amongst a population. In such an algorithm there should evolve a hierarchy as to who goes first, who goes second and so forth – such a list would outline a relativity we call 'preference' (which may be positive or negative depending if above or below another in the ranking). Distributing resources in accordance with such a distribution process would be 'proper preferential access'. One would expect such an algorithm would be determined in a fair and just manner reflecting the modified egalitarian approach characteristic of the Canadian population (after John Rawls as outlined in Appendix A) and that the algorithm would have imbedded rules that cover not only the original placing of groups/individuals but also rules that outline when an individual/group would be 'fairly' moved on the distribution algorithm reflective of changing context. In other words the 'access to care algorithm' must not be immutable and fixed but a living process responsive to agreed upon initial and ongoing criteria. It would be in those circumstances where individuals/groups have care outside of the ranking lists arising from such rules that one would consider this to be 'improper preferential access'.

In your opinion, what would be examples of "proper" preferential access to health care?

Any list one would derive on preferential access would be debated at length with great difficulties to gain consensus since allocation decisions are so context sensitive and reflective of the decision maker's orientation to the issues at hand. Further, clinical judgement dramatically varies between different practitioners, also related to their individual context and orientation. Some of the micro allocation

criteria (and this list is not inclusive nor presented in a ranked fashion) that might be considered in addressing access would include:

- Clinical criteria – As an example, in the Operating Room unscheduled cases are often prioritized utilizing an "E" system with E1 cases to be done in one hour, E4 within 4 hours and so forth. An E1 case might include such things as a patient with an actively bleeding stab wound that needs operative control or a laboring patient with a poor tracing indicating the baby might be at risk. Both would be done before an appendectomy labelled as an E4-6 which itself would be done before repairing a fractured bone which had been labelled an E24 by the orthopedic surgeon managing the case.
- Pathophysiological criteria – If a patient has a cancer that has a recognized "Halstedian" progression wherein the earlier the cancer is treated, the better the outcome, management of this cancer should receive priority over processes that carry less risk. As another example, when deciding which of two patients with hernias should be treated first, a younger patient with a symptomatic defect more susceptible to incarceration would be treated prior to an elderly, sedentary patient with a broad based asymptomatic hernia.
- Social criteria – In deciding when to schedule a patient, consideration of the availability of social supports should be considered. This might include the patient's responsibilities of care for others (such as supporting another family member) or alternatively the availability of other support for the individual during their time of need (such as a mother-in-law availability to come and help care for a young family when the wife is being scheduled for a cholecystectomy). This would respect patient autonomy reflecting how access to services impacts their life; these factors are often poorly documented and tightly held such that the weight they attach to an individual's decision to access services is not always understood or appreciated by others external to this decision.
- Elasticity of supply – It is not unusual for resources to be available in unpredictable manners, not easily available again. This often results in time pressures which necessitate best efforts to use the resource in a fixed time interval. One example would be in the operating room. Cases are scheduled each day

based on average time to complete a case. This means some days when cases will take longer than planned, not all the booked cases will be completed while at other times when cases take less time than planned there will be available time left at the end of the day (this may also occur if a case is cancelled). Spaces in the OR left available in this manner are like airline seats in that all the resources are already paid for and available (anesthesia time, nursing time, etc.) and to have this time available later costs more than using the time now. Accordingly, efforts are taken to fill this time. Depending upon the availability of patients and surgeons this can be a scramble which does not necessarily reflect on the urgency of patient need. However, not using the time and opportunity from a system perspective would be a poor overall use of resources.

- Resource constraints – Access to one part of the system may depend upon joint availability of other resources. As an example, a cardiovascular case may need to be scheduled depending upon availability of a post-operative ICU bed. Although national efforts are made to ensure the highest priority case is offered the next available transplant organ, one of the considerations needs to be the timeliness of being able to provide the transplant itself which will often result in significant rescheduling of previously scheduled cases in the OR for example.

- Commensurality – Commensurality is the ethical principle that distinguishes equality and equity. In public health consideration for example, the access to resources should be commensurate with risk of exposure. Hospital staff working in environments with high exposure to the flu virus should be vaccinated early as they are taking on more risk. Further (similar to putting your mask on first in an airplane prior to helping others), vaccinating care workers and others responsible for public services is a consideration in ensuring maximal total population access to services.

- Access for the "Poor" – First, to be clear, this is not confined to an economic definition of poor but poor in the broadest sense. This is the basis of deontological ethics, the 'walking a mile in somebody else's shoes'. I am referring to what Rawls calls life's 'undeserved lottery' a concept that is very strongly

represented in feminist ethics. In our society there are those who are in unfortunate circumstances, sometimes as a result of externalities, sometimes as a result of how society itself is structured. Lasting societies can often be measured by how they treat their most vulnerable and disadvantaged and this must be considered in regards to access. Another variant to consider here would be disease processes wherein even though there has been no demonstrated survival benefit with earlier treatment there is recognized angst and emotional stress by having the disease untreated – surgical treatment of breast cancer falls into such a category.

- Professional Courtesy – In medicine the stories of individuals 'going the extra mile' are replete – individuals who stay on their own time to support patients, individuals who give of their time and energy to serve patients, individuals who truly treat health care as a calling as much as an occupation. I saw it in practice. I considered it professionalism. Further, health care is so much better if the treating team is truly a team and not a collection of individuals. It is likely a truism that the only way a health care system can put 'patients first' is by those embedded in health care administration of said system to put 'providers first'.

 Accordingly, I believe that there is a place to provide some degree of increased access to those working within the health care professions – not just physicians but all providers. In society as a whole, if my next door neighbor is a plumber, he might help me on the weekend. In the rest of society this might be looked at as a 'black market' in economic terms. The challenge for health care in the Canadian context is that payment for services comes from the public purse. However, especially if the provision of professional courtesy service 'expands' the total pool of potential services I do not believe this is unreasonable as one of but many variables to consider. If a physician sees an additional patient after usual office hours and this does not impact access for the rest of the patients this should be a consideration. The ethical principle here would be physician autonomy that would have to be balanced against societal non-maleficence.

 Having shared my sentiment it is important to recognize this is an issue of great debate and significant historical context. The concept stems from the time of Hippocrates and was first

designed to discourage physicians not to self-treat or treat their families. There was a suggestion that professional courtesy also built teams and fostered better camaraderie amongst physicians. The American Medical Association in their first Code of Ethics (1847) made the reciprocal treatment of physicians and their families an ethical responsibility. This 'professional courtesy' reflected on forgiving payment for services but was silent on ease of access, not an issue at the time. (At that time, physicians often came from lower social classes and struggled in a very competitive market place so that many physicians could not afford care.) Thomas Percival's classic 1803 treatise on medical ethics actually suggested not only physicians but also the clergy should receive such 'professional courtesy' suggesting both did work that reflected benevolence in economically challenging circumstances. The Canadian Medical Association has similarly struggled with professional courtesy, an excellent example of which is provided in an article by Goldman that captures the disparate but impassioned points of view in the mid 1980's (Goldman B. Professional courtesy: my colleagues will no longer be my brothers. CMAJ 1985; 132:422-8.) Until the revision in 1996, the Canadian Medical Association Code of Ethics retained an article indicating charging a fee to a physician or their family was contrary to the Code of Ethics (Article 43 in the 1990 Code of Ethics). The American Medical Association in their current Code of Ethics states in 6.13 that "While professional courtesy is a long standing tradition of the medical profession, it is not an ethical requirement." An excellent summative article in the New England Journal of Medicine suggested at the time the article was written, 96% of physicians in the United States offered professional courtesy, defined as providing free or discounted health care to physicians and their families (Levy M, et al. Professional courtesy – current practices and attitudes. NEJM 1993; 329(22):1627-31.) The authors also suggested 92% of the physician respondents indicated it was an honor to treat a colleague. However, in the conclusion of the article the authors suggested there were ethical reasons to prohibit professional courtesy, especially since physicians were no longer unable to pay for care and there were so many Americans who could not afford health care or had limited access to it. At that time and increasingly so since, there are increasing legal requirements in

the United States making it legally forbidden to forgive co-payments which further complicate this debate.

Paradoxically, there would be a concern that any such 'professional courtesy' may in fact lead to inferior health care for physicians and their families. Physicians would by the nature of their practice see low incidence events often enough to potentially lead to over-investigation which may in turn lead to worse outcomes (Bayes Theorem). Thus, though usually framed as an ethical issue of autonomy and justice there could be an argument from a beneficence point of view that professional courtesy is not justified (very similar to the argument made that routine breast examination at the time of annual examination is no longer recommended given that the effects of over-investigation and over-treatment that result lead to worsened outcomes)

- Macro-Economic Considerations – Though we are considering micro allocation criteria, it is important to remember that the macro and meso allocation decisions also reflect on individual choices. As an example, in rural communities, health care is a major economic driver of the local economies which in turn increases the total health of the community by providing income and jobs. This needs to be considered in determining location of facilities. For example, having a long term care facility in a rural area where it may not potentially be optimally matched to population needs, might allow access to human care resources (underemployed nurses for example) and sustain this local economy. This might also bring into the picture distribution in society of 'obligations' rather than just 'rights' when we consider how far away from their 'home community' an individual should consider when accessing services.

There are wide overarching rules that everyone would agree to in their 'black and white' state. A choice to allocate the next OR space between someone recently stabbed and bleeding to death OR a patient who has been scheduled for several months for a non-life threatening condition would seem obvious to all. The challenge for all of these decisions is that ultimately there will be 'grey areas' that require consideration of the many other factors involved in the context of the decision. Further, it is also important to reflect transparently and non-

judgmentally on the motivations and paradigms imbedded in the choices made by all decision makers in their allocation choices.

In your opinion, what would be examples of "improper" preferential access to health care?

I look to Aristotle who advanced the concept that a virtue is not one end of a dichotomous scale with a virtue demonstrating one extreme and a vice on the other end. The reality is that a virtue is the 'golden mean' between its two associated vices of either excess or deficiency. As an example, the virtue of bravery is between the vice of deficiency (cowardliness) and the vice of excess (foolhardiness). Likewise in the examples that I have indicated above in regards to what might be considered 'proper' access, each can be taken to the extreme of either too much or not enough which would then constitute 'improper' access to health care. As an example, if I use the category that I indicated was access to the 'poor', if the entire health care system concentrated on this group it would create unfair restriction to other groups whereas if this group was ignored we would deteriorate towards an entirely utilitarian ethic of health care allocation – both would be improper. The challenge in our system has to be developing the right balance between the myriad of considerations that need to be considered in allocating resources.

I will also add one other category here that deserves special attention. I will categorize this as the 'squeaky wheel' consideration. This would include a wide array of presentations. One example would be what has become characterized as 'defensive medicine' where a test or procedure is done not because it is indicated but rather because of underlying medico-legal considerations. The challenge with this relates to the at times forgotten reality that all tests are not perfectly accurate with understood rates of false positives and false negatives. With rare diseases, the challenge is that the rate of false positives approaches a rate where the risks of intervention outweigh potential benefits for the net disadvantage of a population – not to say anything about total costs to the system.

The other concerning component of the squeaky wheel would be political interventions – either formally through the political system or informally through what might perhaps be best characterized the 'connected'. Most would agree that preferential access to a health care intervention purely because of advocacy by such a mechanism is not

acceptable. However, here too there are grey areas. Sometimes, this is the only way that an unrecognized need comes to the attention of the system given the knowledge of the individual in need of care. This is navigation in the system. This would be good. However, it would not be good if, after consideration of all other factors, it is purely the relationship with the political champion that forms consideration for priority access. An interesting consideration here is perhaps best demonstrated by the decision to give Mickey Mantle a liver transplant. Although Mr. Mantle was a poor candidate for a liver transplant, he did receive one of the few organs that were available. Of interest however is a reflection that the publicity of Mr. Mantle receiving the transplant actually increased the number of donors which in turn increased the total pool of organs resulting in a net benefit to those in need. This might be considered positive, especially in a utilitarian ethical paradigm.

In your opinion, would you characterize the following examples as "proper" or "improper" access to health care?

i. Physician advocacy – It is imbedded in the Hippocratic Oath and in the fiduciary nature of the patient-physician relationship that the physician is to be an advocate for their patients. This is the same relationship expected in the legal profession. It would be the standard to which physicians would be judged in the legal system. The choice of a physician NOT to provide a test to a given patient would not consider an acceptable defense that other patients needed the test more when *a postori* the test would have made a difference. Changes in physician advocacy would necessitate changes in not only the physician-patient relationship but also the tort system. Physician advocacy is therefore good. The challenge is how to apply a 'gate keeper' to this behavior when there are multiple advocates for scarce resources. Individual physicians as advocates for their patients cannot be expected to serve this population need and we need to look at alternatives. The challenge is when physician advocacy crosses the boundary of fairness so that it becomes a 'win' to get the resource as opposed to fairly advocating for needs of their patients. If physicians are advocating not for their patient needs but rather solely for their economic or power advantage this has crossed a line, especially if advocacy is artificially couched in patient need.

ii. Physician use of emergency OR slots to book patients in for surgeries – Emergencies occur and are unpredictable in regards to volume and timing. Ideally, time should be available in an OR schedule for such cases. There also needs to be a fair mechanism of stratifying emergency cases so that those most in need of care are prioritized. This is completely appropriate. There will be times when emergency slots are available but there are no 'emergency' cases in need of the slotted time. In this instance the OR time (including time of staff and anesthesiologists) is available and already 'paid for', not to be available again. In this situation, filling the time with other, non-emergent cases makes good economic sense. If the time is not used the total waiting time will increase. Thus it is appropriate to use these slots to book patients for surgery and availability becomes an important consideration for using the time. One must also be thoughtful of administrative time in scheduling as it might be more timely and possible to fill the time with a patient not already in the queue rather than moving the whole queue up. Filling the time with patient X might make much more sense than moving A to the available time, B to A's time slot, C to B's time slot and so forth. There are often multiple social reasons that make sudden movements in time difficult to accomplish in the short term that would not make this manageable. There is another challenge with this scheduling that occurs when the patient most in need of an available emergency OR time is available but their surgeon is not (perhaps because he/she is in their office) – this brings in the consideration of having another surgeon available to provide the care. This is becoming very common in the orthopedic surgery environment but not in all environments and adds another layer of complexity in regards to how to best manage, especially when the physician and patient already have a pre-existing fiduciary relationship. This becomes extremely challenging to manage as it brings in patient and physician autonomy against beneficence and justice.

iii. Allowing a physician or hospital worker to obtain an MRI faster than spending time on the waiting list? – Most would agree that all other things being equal, priority access on this basis as a sole consideration is not reasonable in a publically funded system. However, there are many other considerations that apply. The same argument as above applies in that a time slot

that becomes available in the short term should be filled – at times this urgent availability might actually be a physician or hospital worker who happens to be in the hospital at the time the slot becomes available. If the reason to schedule an MRI for a health care worker is directly related to their health care position the principle of commensurality would suggest this should be considered. If for example, they hurt their back providing patient care in the system it might be considered whereas if they hurt their back playing sports outside of the system one might not give this as much weight. The other consideration is the need of the whole system. For example, if several nurses are off work awaiting an MRI and this absence from work means that service will not be available as a direct result of their absence, it might be reasonable to give some weight to giving them preferential access (all other things being equal) to ensure that the system maximizes its potential. A further example of this could be seen in the prioritization lists that were considered during the H1N1 epidemic where prioritization of care to essential service workers such as health care providers, fire fighters and the police service was a consideration.

iv. Hospital or medical staff obtaining flu shots before the general public – In this instance I believe this is right most of the time. Hospital and medical staff would be expected to have greater exposure to the flu virus related to their work in environments with expected higher concentrations of individuals with high viral loads. As well, if the hospital and medical staff contract the flu there are fewer resources to manage those in the population who get the flu. Finally there is a concept of 'herd immunity' where having more people immunized decreases the spread of the flu in care environments. For all these reasons, I think it appropriate the flu shots consider these groups with greater priority.

v. Professional athletes and their families obtaining flu shots or medical treatment before the general public – If the vaccine supply is significantly limited (which is very unusual) the answer would be no. This was witnessed during the H1N1 vaccination program where a hockey team did receive preferential access. The public indicated this was not acceptable and in the context of the severely restricted supply of vaccine such access cannot be justified. However, vaccine

is usually available and our challenge is more getting the population immunized. If the same thing happened this year (hockey team immunized early) where there is no shortage of the vaccine this may actually be very positive in that we have a ashamedly low rate of immunization in our province and it would be hoped that positive public media attention of a hockey team getting the vaccination may actually increase immunization in the public. It is all in the context of the multitude of factors one has to weigh into the decision. If we could be certain that the total number of people getting immunized in a population increases because of the potential positive message that this priority immunization provides (perhaps as a quid pro quo in that the professional athletes would publically promote immunization for this preferred status) then the positive overall population outcome might very well justify this strategy.

The question of medical treatment for professional athletes needs to always consider the clinical context of the presenting complaint of the professional athlete in that injuries that occur as a result of the circumstances that professional athletes are subjected to often demand more urgent assessment because of the immediate risk of the injury and potential future injuries because of the environment in which they compete. Sports injuries and their management has become a separate branch of medicine because of this complexity which is often not considered in determining this access. The access has to be related to clinical need and risk. To add to the complexity of this discussion is the expansion to an even broader discussion as it relates to what type and kind of support a society should provide to its 'elite' athletes who represent our country at international events – when is the outcome for the good of the individual and when is it for the good of a society?

vi. A physician arranging for a friend or family member to be seen quickly – The question would be how this person receives this 'quick' visit. If the visit is an 'expansion of supply' in that it is an additional visit at the end of an office for example, is this any different than a plumber fixing the toilet for his sister or friend? This does relate to the rightful autonomy of physicians within a society to be able to have some control of their environment. A corollary of this question is whether a physician (excluding

emergent reasons) has to see every patient that presents to them. The challenge is when a patient in the queue to see the physician is cancelled or deferred because of this preferential access which is potentially more problematic and relates to the context of patient need (beneficence and non-maleficence) balanced with physician autonomy.

vii. Politicians/donors/philanthropists being seen in emergency without waiting (depending on the nature of the problem) – The moral argument might be that since this group has been involved in increasing the size of the health care 'pie' by the decisions they have made in the past or might make in the future this would entitle them to preferential access as without these additional resources less total resources would be available so the overall net good outweighs this individual behavior. This is a utilitarian argument and I am not swayed by this argument. I believe this kind of preferential access is not justified in the Canadian system. The politicians/donors/philanthropists have both rights and, equally as important, obligations related to their positioning. We should be striving to provide a system that provides optimal care to all. Ultimately such a desired system will result in decisions to optimize resources for health care, be it through political decisions, donations or philanthropic efforts. Any preferential allocation via the politician/donor/philanthropist route also has the risk that the next investment in health care is made to reflect the personal wish of an individual rather than reflect on the most pressing needs of the population. Of all the questions that were asked in this section, this is the one that I have seen asked all too often and which I am most troubled by.

Are you aware of any safeguards which currently exist in the health care system to prevent "improper" preferential access effective?

1. Media – the media is a powerful means of oversight by shining lights on issues of concern in resource allocation. The challenge is that the media tends to look at individual rather than population outcomes which can create challenges of its own. Unusual events make for much better news stories than public health campaigns which also risk skewing public expectations. Another challenge is that confidentiality of individual patient

decision making criteria may prevent full disclosure of the clinical scenario and risks.

2. Regulatory Colleges, especially the College of Physicians and Surgeons of Alberta (CPSA) given the preponderance of physician involvement in micro allocation decisions. The CPSA has a robust process to evaluate complaints and concerns about physician behavior and this oversight role needs to be complemented by increasing promotion of adoption of standards of care. The CPSA has a legislative framework that incorporates members of the public in reviewing troubling cases that adds value to the process.

3. Underlying virtue ethic of health care providers. At the end of the day the vast majority of physicians make these allocation decisions responsibly and collaboratively each and every day. This is the 'virtue ethic' of physician behavior since the time of Hippocrates. We do not have robust enough data and information systems in the present environment to develop a system to replace this.

4. Increasing emphasis on booking protocols to rationalize resource use. An excellent system developed in Ontario (often referred to as pCATS) for pediatric surgical patients and spread across the country (*Can J Surg.* 2011 Apr; 54(2):107-10 presented as an abstract at http://www.ncbi.nlm.nih.gov/pubmed/21443828) is an excellent example of the power of these targets. Alberta is currently working with BC to develop similar targets in the adult world. This needs to continue.

5. Increasing involvement of physicians in administrative roles. In several jurisdictions development of dyadic leadership models have evolved. The hope is that greater engagement of physicians in roles such as these will lead to more robust gate-keeper rules and roles.

6. *Health Professions Act* (HPA) has better defined professional roles, scopes of practice and complaint mechanisms that in their entirety have the potential to provide more transparent and just oversight.

Do you believe that there are changes that can be made to the existing health care system to avoid or prevent "improper" preferential access?

1. Greater differentiation and transparency between macro and micro allocation decision makers in the system. The Ministry should concentrate their efforts to macro allocation decisions and strategy, deferring meso and micro allocation decisions (tactics and operations) to Alberta Health Services or its equivalent.
2. Increasing emphasis and implementation of Standards of Practice. There are existing and evolving standards of practice guidelines that need to be more widely implemented and adhered to.
3. Continuing work and implementation of pCATS and similar such scheduling tools.
4. Ongoing dialogue and development of priority tools. One of the most developed of these is the Western Canadian Wait List (WCWL) project (http://www.wcwl.ca/) that is most mature in its development of ophthalmology priority tools. This project involved wide discussion and engagement to help inform these standards.
5. Rationalization and optimization of physician leadership dyad models. These are very costly administrative modes that need to be optimally applied. The challenge with physician dyads is to clearly define roles of the various partners and ensure that the physician role reflects the need for increasing adoption of standards of care and quality of care initiatives and is complementary and not duplicative of administrative roles currently in place.
6. Comprehensive and transparent outcome data. While we have much process data we do not necessarily have robust and defensible outcome data. In this instance the challenge is a bit of data is likely just as dangerous as no data as the outcomes will not be properly risk stratified. As an example of where this is a challenge we might look at publishing outcome measures on the web for surgeons. If, for example, I am a general surgeon and my hernia recurrence rates were to be published I may very well choose never to operate on a smoker again as

they have higher recurrence rates. There are often many other reasons why a patient may not do well and unless ALL this information is transparently captured one runs the risk of making decisions on incomplete data that may actually adversely affect those most in need of care.

7. Review of the *Health Professions Act* (HPA) to ensure it has the mandate and role for each of the Professions to have valuable oversight of their members. This must include transparency and involvement of the general public. The HPA was a beneficial step forward but I would suggest needs refinement based on the initial experience of the last few years. It is my understanding there is some discussion of reviewing this Act in the next few years and I would strongly encourage this as the HPA needs to ensure there are forums for this discussion.

8. There must be defined overview of booking systems within individual institutions that incorporate the input and feedback from all the health care team involved in the system. In my clinical practice there had been a mechanism to review any emergency cases that were booked as an emergency within the hospital when there were concerns. This should exist in all hospitals for all services. This should look not only at emergency cases but also scheduled cases.

9. Over the last many years resources have been prioritized towards the 'big 5' as first defined in the late 1990's by the Federal Government with funding (hip/knee replacement, coronary artery bypass, cataracts, and MRI/CT). We measure how many of these we have done (quantitative data) rather than whether we have made a true difference on outcome. We need to develop more robust systems to determine we have truly made a difference in outcome of patients rather than just measure numbers of procedures done. For example, when it comes to hip and knee replacement, do we have it right that we are concentrating on these procedures rather than perhaps allocating greater resources on prevention? This is likely best captured in an excellent article by Dr. Michael Porter in a 2010 New England Journal of Medicine article titled "What is value in health care?" where he emphasizes we need to consider value as dependent on results or outcomes achieved, not inputs. The questions need to be asked in a wide, transparent forum outside of decisions made by governments in the past.

10. Political emphasis needs to shift to the "Triple Aim" described by the Institute for Healthcare Improvement which concentrates on patient experience of care, improving the health of populations and reducing the per capita cost RATHER than wait times in one part of the system – an emphasis akin to pushing in a bulge in a balloon with bulges occurring in often unexpected places. We need to concentrate on ensuring we provide the right care at the right place by the right provider and times will look after themselves. Unless the system can take the broader approach concentrating on marginal costs health will remain a political juggernaut in the realm of politicians rather than health care providers. This will take political will and skill.

DISCLAIMER: The above represent my personal opinion only and not that of any previous or current employer. Prior to completion of this document I did have a leadership role in Alberta Health Services and near the end of the completion of this document I did assume a role with the College of Physicians and Surgeons of Alberta. Much of this information is imbedded in the Fellowship paper I presented to the Canadian College of Health Leaders and I have copied some of this information directly. The entire paper is available at http://www.cchl-ccls.ca/assets/FellowProjects/OwenHeisler_FellowshipProject.pdf.

Appendix A: Macro-Allocation Resource Allocation Ethical Frameworks

Classically for a macro allocation decision the major concern relates to concepts around distributive justice – how do we 'justly' distribute both rights and obligations within a society? The two basic models to consider are libertarianism and egalitarianism. While libertarianism would be most closely represented by the health care system in the United States, a modified egalitarian approach would be closest to the health care system in Canada.

Libertarianism argues that the only thing we owe to each other in society is non-interference; individuals acting in this freedom framework will maximize their personal goods and consequentially increase the 'value' of society. Maximization of civil liberties in this model does not consider health a basic civil liberty but rather a commodity.

The egalitarian approach to allocation of health care resources recognizes health as a basic right of the human condition with basic health an intrinsic civil liberty. Egalitarians argue that, in the principle of justice and fairness, the resources of all of society need to be equally distributed as a basic envelope of health services to all individuals in society to maintain the health of all individuals. Egalitarians believe the development of a more healthy population is the only way to ensure individuals can maximize their potential and in so doing increase the 'value' of society.

A total egalitarian approach argues for completely equal distribution of all resources while a modified egalitarian approach argues for equitable distribution, differentiating equity from equality. Much of this thinking is based upon the work of John Rawls and further elucidated in the health care environment by Norman Daniels. Given the Canadian environment where the ethical framework of Rawls has become so prominent it is worth looking at the Rawlsian ethic in greater depth.

Rawls' theories were clearly based in a deontological approach stressing the importance of normative principles of intention. He looked for universal fundamental principles that could be applied to individuals to facilitate harmoniously living together as a society. The principle of greatest concern to Rawls was the principle of justice. He

concluded that we ought to decide what is right and wrong human conduct based upon fairness as the most important aspect of justice. Justice as fairness became the basic tenet of Rawls' approach. He advanced two principles that he believed were integral to justice. The first is that each individual in society has an equal right to the most extensive liberty possible compatible with an equal similar liberty for everyone in society. Second, Rawls suggested for a society to function properly there are reasons permitting inequalities of liberties between individuals. These inequalities might exist because of a necessity to provide greater benefits to fulfill a need to attract individuals to certain jobs or positions. A very basic example would be in distribution of food - should a one hundred pound sedentary retired individual be allocated an identical amount of food as a two hundred and fifty pound laborer? Equality would say yes while equity would say no. Differences also exist as part of human nature, realities Rawls referred to as life's undeserved lottery. Rawls' principle flowing from this line of reasoning was that where inequalities exist, they have to be open to all and ultimately work out to the advantage of everyone. It is the burden of proof of those with the greater liberties to demonstrate their greater advantage is for the good of all of society. Rawls did not dispute there are examples when society itself sets these inequalities, as for example the theological/religious rationalization for a caste system.

In his arguments Rawls was most concerned with functions of a society and made an unstated assumption that all individuals in society are 'context' free with each individual having an equal 'deserve' to everything society offers. He further assumed equal opportunity for all individuals to have equal access to liberties presuming all persons are rational with roughly similar needs and interests. Rawls believed offices in society must be available to everyone. In such an environment each individual should be able to look at his/her situation with a 'veil of ignorance' and accept that given the situation leading to inequalities, the reason for any difference would be robust enough that he/she would accept either the 'advantaged' or 'disadvantaged' position, understanding any existing difference was for the good of society. Flowing from this 'veil of uncertainty' Rawls argued each individual would be wary of proposing governing principles which gave him/her a peculiar advantage for fear that in the future this same principle, if unfair, might be applied against him/her. This would leave no easy way for anyone to win special, unwarranted advantage for himself/herself. Persons engaged in such a just practice would be able

to face one another honestly with mutual acknowledgement and respect.

This 'fair play', Rawls argued, needed to be recognized in society beside the complementary principles of fidelity and gratitude. All three principles imply constraints on self-interest that are essential to society where realization of aspirations of others is at times required for the maximal benefit of all. Rawls was very clear to clarify he was not suggesting his theory was utilitarianism which he characterized as welfare economics. Rawls acknowledged that at times the outcome from a utilitarian perspective and his perspective might look the same. The difference, he argued, related to the intention that led to the outcome. In utilitarianism any differences in liberties are administrative and have the potential to relate to 'accidents' of education or upbringing. The resultant inequalities of liberty are assessed on the basis of diminishing marginal utility and are entirely teleological (outcome) based. For Rawls, his conception of justice as fairness was entirely duty based. He was clear to differentiate 'unintended' positions in society based on life's lottery from those relating to free choice. An example of the differences in the two approaches would be the treatment of disabled individuals – for a utilitarian, allocating few resources to this group might lead to algebraic maximization in society whereas for Rawls this is an unintended positioning and the question back to society would be what would a given individual have expected had he/she been born into this situation. Different outcome!

The fundamental moral concept of justice as fairness arises directly from the reciprocal relations of persons. If a claim of uneven distribution of liberties were not in accordance entirely with principles, Rawls, similar to Kant, would argue there would be no moral value in granting this position. The arguments for and against slavery demonstrate how this concept is applied. Whereas utilitarians might assess the advantages of the slaveholder compared to the disadvantages to slaves and society, from the perspective of Rawls, any potential gains of the slaveholder cannot be considered at all as the absence of societal gain already dismisses the argument.

Appendix B: Micro-Allocation Resource Allocation Ethical Frameworks

When considering micro allocation decisions the questions from an ethical perspective become normative questions of right or wrong, good or bad. The four basic ethical/moral theories addressing such questions are utilitarian, deontological (Kantian), virtue (Aristotelian) and feminist. All four theories are concerned with normative concepts of right/wrong and what we 'should' do when considering options to come to a right and just decision. Of these theories, one (utilitarian) looks at consequences, one (deontological) to motivation, one on the actor (virtue) and one towards context (feminist).

Utilitarianism as originally proposed by Bentham and Mills and expanded by many others over the years is consequence driven. The rightness of an action relates entirely to an algebraic determination of the production of overall happiness. The correct act is that act which maximizes happiness no matter what it takes to get to this point – the end justifies the means. In its pure form, all outcomes are known and can be measured and actions are entirely impartial. Major concerns with this 'act utilitarianism' is the realization that optimal outcome will invariably be realized with a strategy of maximally disadvantaging a small group in society for the 'greater good'. Three major concerns with a pure utilitarian approach are disadvantaging a few for the advantage of the majority, acceptance of acts that many would consider inherently wrong such as torturing innocent people, and the promotion of individuals acting only for their own good (free riders). These concerns prompted some utilitarians to develop an alternative known as 'rule utilitarianism'. In rule utilitarianism the rightness of an individual action is not related to its *direct* consequences but rather the *universal outcome* should this individual action became the general rule for behavior. Rule utilitarianism is thus more concerned with the kinds of acts that are done, at the same time still arguing that these kinds of acts be evaluated on their ability to promote maximal overall happiness. Whether or not the ideal world this supposes can exist and whether for a true utilitarian this rule utilitarianism does not revert to act utilitarianism remains contested.

Deontological ethics, in direct opposition to utilitarian ethics, argues that adherence to duty, rather than consequences, is most important in analyzing the rightness of an action. Immanuel Kant, who first

advanced this moral theory, proposed that actions are right when they satisfy the "categorical imperative". He suggested general rules or 'maxims' be considered when evaluating the rightness or wrongness of actions and that these maxims should adhere to one of three formulations of this categorical imperative. The three formulations are 1) maxims should be able to become universal laws, 2) maxims consider treating humanity as an end and never only a means and 3) maxims treat others as autonomous agents. Whereas a utilitarian would justify telling a 'white lie' this does not exist for a Kantian since lying could never become a universal law. Deontological ethics are based on four basic principles of beneficence (the Golden Rule - do good), non-maleficence (the Silver rule - don't do bad), autonomy and justice. One of the challenges for deontological ethics is what to do when adherence to discreet principles collide. In the health care environment, should a patient's right to autonomy trump what would be the most beneficial treatment plan for the individual? This lack of consideration for context, emphasis on consideration only of rational autonomous beings (discounting non-humans and cognitively impaired for example) and variable formulation of maxims has challenged the Kantian deontological moral theory.

Whereas both Utilitarians and Kantians examine actions, virtue (Aristotelian) ethics consider the actor. Kant specifically indicated that if an individual performs an action within his/her character this is not to be even considered a moral action. Aristotle, the founder of virtue theory, proposed that it is/was consideration of this very character that is in fact paramount. The actor is more important than the action. Aristotle proposed primary importance is development of virtuous people. Virtuous people will 'naturally' do the right things and we do not need to consider their actions since all actions will be natural outcomes of their character. Being virtuous is a learned behavior that can be taught but requires considerable practice. If a virtue is considered the 'golden mean' between two vices, virtuous individuals consider alternatives, deliberate about them and, as a result of their training, voluntarily choose the correct action based upon the nature of humans to aim for *eudemonia.* Eudemonia represents the state of happiness and well being that, according to Aristotle, is fixed in human nature. It is concern with this concept of what is natural that remains debated in Aristotelian ethics. The lack of direction in evaluating both actions and the progress towards being virtuous are other difficulties with Aristotelian virtue ethics.

Feminist ethics arose because of concerns that classical moral theories not only did not consider gender but, more globally, did not address oppression in all its forms. The lens of the feminine gender is proposed more revealing than the more masculine humanist perspective reflecting experiences and intuitions of women that emphasize caring, friendship and relationships. The context of an act is vitally important and acts should not be universalized (as per Kant) or simply outcome summed irrespective of whose happiness and the nature of the happiness (as per utilitarianism). In feminist ethics there is greater emphasis on justice than the absolute nature of autonomy imbedded in previous theories. Similar to virtue ethics there is an absence of rules and/or calculations for making individual decisions.

Health care ethics until the mid-1950's were based on a virtue ethic emphasizing the care provider more than the specifics of decisions being made – the actor rather than the act. This theory promoted the virtue of training competent physicians, nurses and other health care providers who would then make good decisions; it is the theory underlying paternalistic attitudes of physicians in the past that are still seen at times today. This is the basic ethical paradigm that underlies the Hippocratic Oath and the fiduciary nature of the physician-patient relationship. In the middle of the twentieth century health care evolved towards a principle based deontological ethic concerned more with beneficence, non-maleficence, autonomy and justice. Imbedded in and influencing both these paradigms were utilitarian ethics promoting strategies to maximize happiness - always a major consideration especially when considering equitable rather than equal distribution of scarce resources.

Physician-patient relationships over the last half-century have demonstrated a decrease in paternalism creating an increasing 'challenge' from the physician perspective to balance what a physician 'knows' is best for the patient and what the patient 'wants' (if and when there might be a conflict). Physicians are increasingly, and with some distress, being asked not only to ensure that the patient in front of them has optimal care but simultaneously to ensure fair population access to limited resources by acting as gatekeepers to an increasingly expensive technological environment of scarcity. When lawyers are asked to leave their fiduciary advocacy role they become judges – physicians have not historically been granted the same 'changing of hats'. A legal environment that is perceived to demand primacy to the fiduciary

responsibility for physicians magnifies this picture of existential conflict.

When physicians are asked to assist management with allocation decisions of resources to populations the basic orientation of physicians towards individuals creates ethical dilemmas. As medicine becomes progressively more technology based physicians often feel compelled to respond to allocation decisions for new, most often expensive technologies on the basis of not just what is *good* but what is *best* for their individual patient. In being asked to make determinations of resource utilization, physicians should ideally evaluate the marginal value of interventions in an environment where outcomes are uncertain. For example, when only one CT scan is available should a physician order a seventh scan on a patient where it might be expected to add just a bit of value or the first scan for a different patient where one might assume the scan could add potentially more value? Given the answer to these questions can only be determined a *postori* once both scans are completed, these a *priori* decisions become doubly difficult when evaluative criteria invariably consider developments beyond the time frame during which the decision must be made. To add further to this challenge is an environment where there is often significant marketing pressure by pharmaceutical companies and medical equipment manufacturers who are promoting their interventions and a public who are exposed to both advertising and anecdotes in an increasingly networked, internet-worked environment.

What is the right balance between advocating for individual patients and advocating for the rights of an entire population? Codes of ethics equally stress both the importance of the wellbeing of an individual patient and the importance of looking after the whole of society. Rather than providing direction when there are ethical conflicts, these codes support both sides of the debate equally. This means these codes are usually not helpful in managing conflicts that inevitably arise in allocation decisions when different principles clash or the needs of the population and the individual are at odds. The codes in fact can lead to greater polarization as tools to capture the moral high ground in conflict situations.

Another way to characterize this paradigm conflict can be captured in a two-by-two diagram. On one axis we can consider the two major competing ethical perspectives – deontological versus virtue/utilitarian. On the other axis will be whether one is considering applying the

ethical framework to an individual or a population. Each of the four resulting approaches can be characterized in the diagram. The following paradigms exist:

	Utilitarian/Virtue (Outcomes Based)	**Deontological (Duty Based)**
Individual	Hippocratic	Respect for Persons
Population	Social Utility	Social Justice

In this framework, physicians classically have been positioned in the upper left box reflecting their fiduciary relationship to individual patients. It might be suggested elected officials (funding agencies) gravitate towards the bottom left box – maximum outcome for a population usually means the best chance of getting elected. The challenge with this box reflects a reality that the way to maximize outcome for a large group is to significantly disadvantage a small minority group. The media would likely be best represented in the top right hand corner. The challenge here is that the way to optimize this paradigm is to limit what is provided to only those things that can be provided to all. Further, the challenge is that if one, for example, develops a policy which results in avoidance to ten of a potential bad outcome while at the same time directly creating a negative outcome to one (net happiness of 10 – 1 = 9), since we cannot identify the ten who did better (nothing bad happened) and can easily identify the one having a negative outcome the policy is doomed to failure. This is a reflection of the power narratives and stories are given in health care communication. It has been said health care communication is the slave of the anecdote. Although a powerful communication tool, this communication style can be a significant impediment to introduction of evidence based protocols and initiatives that are more population than individual based. We have no way to measure and identify individuals who were prevented an adverse outcome so when 'bad side effects' are identified we do not have the balancing patient where harm was averted.

It should be the goal of all health care leaders, especially physicians, to ensure that we all strive together to be where we need to be - the

bottom right - social justice. The challenge is the multitude of ethical frameworks involved in the transition to this framework for physicians. When considering asking physicians to provide principle based direction on distribution of resources to a population, one must consider the multitude of demands placed on the physicians in a very complex health care environment by those advocating for social utility (government) and those advocating for rights of individuals (media). Appealing to 'professionalism' as a reason for physicians to participate in these difficult decisions does not recognize the paradigm change involved when fiduciary responsibilities conflict with managing needs for a population. The other challenge is that professionalism, if not the classical fiduciary physician-patient relationship, is not clearly defined leading to a great deal of ambiguity. Appealing to professionalism and ethics to advance physician participation in population initiatives, while a powerful strategy, must therefore be respectful of a wide view when utilized. It often is not.

Supplementary Questions – February 2013

In your opinion, would you characterize the following examples of access to care as:

- ***Preferential access or not preferential access;***
- ***If you determine it to be preferential, is it "proper" or "improper?"***

Please explain, briefly, the reasoning behind your opinion.

S1 – Emergency Department Care

Providing high profile people with a separate waiting area away from the general public;

Preferential Access – Improper – Emergency Departments should rightly be reserved for emergent needs and not as a replacement for care in the community. There are often separate waiting areas for pediatric patients; with time there may need to be separate areas for bariatric patients. At times if there are significant infective diseases (such as H1N1) segregating potentially highly infectious patients may be considered. All these are for patient comfort and needs. However, segregating because of the profile of the patient would be improper.

There is no ethical principle that would support this. The issue might for example be a 'star' hockey player concerned he might be approached by other waiting patients – from my perspective this would be one of the unfortunate obligations that are associated with the privileges attendant with the high profile.

Providing priority access to care for doctors, nurses or AHS staff and/or family members accompanied by doctors, nurses or AHS staff;

Preferential Access – Improper – When I recently presented to the ED with back pain, I waited my turn (5 hours). I would expect the same of others. It is incumbent on all health care workers to appropriately utilize the emergency department and work within the system to ensure that the ED is appropriately utilized for emergency and urgent care – not as a way to facilitate more rapid access to care. This is unfortunately the behavior of many (entire population and not just health care workers) in which case ED's evolve as a surrogate for care that is best provided outside of this acute environment. As a professional courtesy a physician may choose to see patients in their office with 'priority access' as a reflection of their autonomous choice (discussed below) but this does not extend to community resources such as emergency departments. An ED needs to be considered a community resource that provides care almost exclusively on the basis of urgency of need.

Physicians asking their own patients to go to the ED to receive elective procedures;

Not Preferential Access – The challenge here is the word 'elective' that should be removed from this conversation. There should be only scheduled and emergent. Physicians advocate for their patient's needs. If a patient requires services that cannot be reasonably and appropriately obtained in a scheduled manner, utilizing the ED for all such patients (and not just a privileged few) might eventually be their only choice.

This is a system issue. As an example, in an attempt to hit 'targets' in the ED, one strategy is increasing ED access to diagnostic services and procedures to facilitate quick throughput in the ED. With scarce and fixed resources, this leads to fewer resources available for patients waiting for these same services in the community. The ensuing vicious

cycle continues wherein patients in the community wait longer and longer so that they eventually have no choice but to go to the ED where they get the service which in turn increases community waits even further. The unfortunate logical conclusion to such a process would be all care would be provided in the ED – not good care.

This question is not the ethical decision of a physician to access services or procedures in the ED but rather the resource allocation decisions that are made within the system. The system has a responsibility to allocate resources in a manner that the needs of ALL populations (and not just those in the ED) are considered. Physicians choosing to access what is available for their patients is not unethical. They are making the best decision they can balancing beneficence and non-maleficence. The question as to the ethical decisions in regards to the fair distribution of resources across the continuum is not so solid.

S2 – Physicians

Responding to requests to see patients in their office quickly by slotting them in before or after normal office hours or on the weekends;

Preferential Access – Not Improper – This would respect the autonomy of the physician. There are currently no limitations as to where a physician can practice or the scope of his/her practice. In the past there had been direction that new graduates not practice in busy metropolitan environments – these were struck down in the courts. There have been previous attempts to control where physicians practice to better match physician supply and patient demand. In the same vein many physician practice 'boutique' medicine that may not reflect the needs of the population. This has always been a challenge in the Canadian system where the costs of physician education have historically been heavily subsidized by the public purse in the absence of clear deliverables by the physicians that graduate and benefit from this system.

The number of hours any physician works is not mandated – some work few hours, some work extraordinarily long hours. (There are concerns that seeing too many patients and too few patients may reflect a decreased quality of care but there has been no limitations imposed on any of the above.) Accordingly, in this environment where physicians have the right to control their own hours – if they choose to

see someone outside of regular hours as a matter of professional courtesy this would be their autonomous right to do so. The proviso remains that once physicians have entered into a 'contract' to see a patient by having booked that patient into their offices, they cannot discard this contract to see someone else preferentially unless there is defensible clinical need that demands such rescheduling. There is an ethical responsibility to manage this patient population as well.

It is recognized that the payment for such expanded service comes from the public purse. However, there is currently no restriction on the number of patients seen by any physician. No physician has a limitation as to the number of patients they can see and one of the arguments for a fee for service model is to maximally provide service. In the absence of such limitation, it is not germane to the argument the payment source since the payment for such a patient does not interfere with the ability to see another patient.

Physicians writing prescriptions or providing medical care for friends, family or colleagues outside of their medical office;

Not Preferential Access – Firstly, it is unethical for physicians to provide care to their families except under emergent conditions (Code of Ethics #20). Otherwise, it would be the autonomous choice of the physician where care is provided for all the patients they see. Physicians in the past did house calls and many continue to provide such service to their patients. If this care is provided to friends, colleagues or patients, the key is that the care is appropriate for the needs of the patient and there is appropriate care provided.

S3 – Private Health Care Facilities

Do membership based private health care facilities constitute an example of preferential access?

Preferential Access – Consistent with Current Norms – In Alberta, 30% of health care costs are not covered by the public purse – the greatest cost is pharmaceuticals but other professional services such as physiotherapy also fit into this category. The Canadian system does not universally provide access to all health services so the ability to pay does make a difference. I knew in practice there were patients who would not be able to afford prescriptions so did not get similar care based on their ability to pay. Public policy has indicated that in the

current environment there is not a willingness to include these services in the public purse as it would require additional taxation.

We as a society need to determine what constitutes a reasonable basket of services that we will provide to all members of our population. This is a conversation that will need to be had very soon. It is impossible given the growth of technology and 'personalized treatment' such as individualized chemotherapy for society moving forward to cover the costs of all possible treatments. An example would be a recent novel treatment for CF that is estimated to cost $300,000 per patient per year treated. My personal thought is that at some time this 'basic basket' must be transparently defined. Perhaps, as part of such a discussion, inclusion of an insurance mechanism to manage the remainder of potential services might be considered. Society could decide if the cost of insurance coverage for vulnerable populations would be something they would consider providing. However, this is not the case now and society does have preferential access to non-insured services.

Private health care facilities have indicated that the membership fees they charge is for 'non-insured' services and not for access to insured services such as physician fees. The membership fee is therefore an example of preferential access to these non-insured services. It is no worse than what currently exists.

It is the personal decision of individuals if this health care allocation is proper or improper. My personal opinion would favor improper as I have outlined above – this improper determination however relates to the universal rather than the particular in this situation.

S4 – MLAs or their Staff

Providing advice to their constituents about wait times, alternate care options etc.;

Not Preferential Access – This is reasonable. Many people do not know how to access the health care system. This is not preferential access as this service would/should be available to the entire population.

Requesting special consideration for a constituent by communicating directly with a health care provider;

Preferential Access – Improper – There is no natural or expected relationship between an MLA and the health care provider. Such a request would suggest there would be an inappropriate *quid pro quo* implied which would be wrong.

S5 – Senior Hospital or Health Authority Officials

Requesting special arrangements (eg: private room, anonymity etc.) for a VIP or high profile patient;

Not Preferential Access – I am assuming the care here relates to 'special' services outside of direct health care. Private rooms are already in the category of non-insured services. Anonymity is something that the general public does not typically need or want. Having said that there are instances when any individual may benefit from anonymity such as might exist for a patient on a psychiatry ward where direct contact with a member of the public may be detrimental to their own health. I think services such as private rooms and anonymity would not be unreasonable as long as other patients with contextually sensitive 'special' needs are likewise considered.

Calling front line staff to make them "aware" that a VIP patient is in the hospital or in the system.

Not Preferential Access – I would reflect back on the recent suicide in the UK of a nurse who was looking after a VIP committing suicide. VIPs bring an interest and entourage that impede not only their care but those of others in the same ward. I do think that front line staffs being aware is very reasonable so they can appropriately respond to events or comments in this context. There should not be a problem sharing such information to make the staff aware.

Academic Literature Review of Preferential Access to Health Care in Canada

Dr. Nishan Sharma

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3. Academic Literature Review of Preferential Access to Health Care in Canada

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Preface

In the introduction to his book "Chronic Condition", Jeffrey Simpson declares that "Canadians embrace their public health-care system, Medicare, more passionately than any other public program". Simpson goes on to assert that Medicare's foundation is equity. Perhaps implicitly, this includes an understanding that access to services, while not necessarily equal, is equitable – with "highest need" being the key determinant of who gets what service and when.

On the matter of equality, differences in access to a variety of health care services for Canadians are well described. Many differences relate to issues such as geography, where the concept of fairness is necessarily dominated by reasonable pragmatism. For example, every community in Canada does not have a trauma surgery team; therefore a significant number of Canadians will have unequal access to potentially life-saving care. Few would argue that positioning such teams in regions with high density or volume is unfair to citizens in other regions.

This review, commissioned by the Health Services Preferential Access Inquiry in Alberta, attempts to focus on the understanding of differences in access that may carry a perception of inequity or unfairness for Canadians. For purposes of this document, these differences in access are referred to as "preferential access".

The author acknowledges that "highest need", fairness and pragmatism often have a large subjective element, and that the perception of these concepts, and therefore the notion of preferential access, will necessarily vary amongst individuals and groups.

Executive Summary

- This report is a review of the academic literature on the topic of preferential access to healthcare as it pertains to the Canadian system. Referencing peer-reviewed journal articles that are applicable to the Canadian context, this review helps define

what preferential access or "queue jumping" means in the Canadian healthcare system from an academic point of view.

- There are few studies that examine the topic of preferential access in the Canadian healthcare system. The academic literature regarding preferential access does not provide empirical, objective data on the practice, but focuses primarily on more subjective, survey-based and case-based data.
- The literature suggests that preferential access to healthcare in Canada may occur:
 - As a result of patient socioeconomic status, whereby preferential access is gained by those with greater means.
 - Through the factors involved in creating, managing and accessing waitlists that are subject to interventions that promote either preferential access or equitable improvements to access.
 - Through variation in the criteria and processes used by physicians to generate referrals to specialty physicians.
 - When physicians practice "professional courtesy".
 - When patients are prioritized through their affiliation with particular organizations.
 - When patients are prioritized based on being deemed "very important people".
 - When "two-tiered" healthcare systems allow patients quicker access to care when they are able to pay for service.
- While some authors question whether it is even advisable to try and address preferential access, there are others who suggest that there are educational, legislative and functional strategies that can help mitigate the practice. These strategies are outlined in this report.
- Academic research in the fields of medicine, law, business and sociology must continue in order to grow the understanding of what impact preferential access has on Canadian society.

1. The Context of this Report

This report, commissioned by the Health Services Preferential Access Inquiry in Alberta, is a review of the academic literature on the topic of preferential access to healthcare as it pertains to the Canadian system. Referencing primarily medical, peer-reviewed journal articles and excluding popular press/media pieces on the topic, this review helps define what preferential access or "queue jumping" means in the Canadian healthcare system from an academic point of view. Given a lack of objective data on the prevalence of the practice in Canada, this report does not address the impact of preferential access and the harm it may cause, but does outline where the healthcare system may be vulnerable to queue jumping. This report also reviews the case made in the literature as to whether preferential access can be mitigated, and outlines strategies that may be employed to reduce queue jumping.

2. Literature Search Methodology

After consulting with W21C colleagues on the scope of the topic, search terms for "preferential access" were modified and then expanded through guidance from a Research Librarian in the Faculty of Medicine at the University of Calgary. In addition to medical literature databases, searches were conducted in business, legal and sociology archives. The key terms listed in Table 1 (below) were then used to retrieve potentially relevant papers from the academic literature databases listed in Table 2. For each potentially relevant article found, "find similar citations" (based on key terms) and "cited by" (linking to other articles referencing the potentially relevant paper) functions were used to further expand the search. Finally, after reviewing the search results, additional papers were retrieved based on references listed in relevant articles.

2.1 *Literature Search Results*

The search terms used in Table 1 yielded a total of just under 700 articles potentially relevant to the topic of preferential access to healthcare. Relevance and potential relevance was based on the judgment of the report's sole author. Of the potentially relevant articles, more than 70% came from medical databases. The Canadian business literature and legal databases yielded no relevant papers.

A scan of the potentially relevant articles resulted in a total of 37 articles downloaded for in-depth review. The literature cited in these yielded an

additional 15 articles for in-depth reading, for a total of 52 relevant articles.

Table 1 - Terms used to search databases for review of preferential access to healthcare. Note: Due to the general usage of these terms, searches were paired with the terms "healthcare" and "Canada" where applicable to limit results to more relevant articles.

Term	Related Terms
Preferential access	
Queue jumping	
Waiting lists	Wait list, wait listing
Health services accessibility	
Resource allocation	Health care rationing
Professional courtesy	
Fee-for-service	

Table 2 - Scientific and peer-reviewed literature databases searched for review of preferential access to healthcare.

Database Name	Domain
MEDLINE	medicine
PubMED	medicine
Index to Canadian Legal Literature	law
CBCA Complete	business
CINAHL	nursing and allied health
Google Scholar	general

3. Defining the Issue

Describing what *preferential* access means, and whether the practice occurs in the healthcare system, requires an explanation of what access to healthcare means in Canada. That is, by understanding what fair access is, one can begin to discuss what is unfair.

3.1 *Defining Access*

The *Canada Health Act* defines the principles and standards to which provincial and territorial health insurance programs must conform in order to receive transfer payments from the federal government for healthcare (Department of Justice Canada 1985). Provinces and territories must adhere to conditions under the headings of public administration, universality, comprehensiveness, portability, (and most important here) accessibility. Specifically, the *Canada Health Act* states "the health care insurance plan of a province must entitle one hundred percent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions…" (Department of Justice Canada 1985). The general terms of the Act have led to discussion of what "access to care" might mean (e.g. Baltzan 1999), but as Cunningham et al. (2012) note "the principles of the *Canada Health Act* include that health care not be impeded by social or financial factors".

3.2 *Defining Preferential Access*

This report equates preferential access with the term "queue jumping", which is defined by Friedman, Schofield & Tirkos 2007 as "the favorable placement or prioritization of a patient in a waiting list for reasons other than medical need".

Whether it is varying definitions or criteria to establish "medical need", or practices in the healthcare system that go against the principles of providing care to the sickest patient first, there are a number of ways that individuals may obtain preferential (read: unfair) access to healthcare. These circumstances are described below.

4. Preferential Access to Canadian Healthcare

Given the definition of fair and "unfair" practices, there are seven themes that cover the preferential access to Canadian healthcare debate in the literature. Various authors have made cases that preferential access exists and occurs:

- As a result of patient socioeconomic status, whereby preferential access is gained by those with greater means.
- Through manipulation of the criteria that are used to evaluate patients and generate waitlists for healthcare.

- Through variation in the criteria used by physicians to generate referrals to specialty physicians.
- When physicians practice "professional courtesy".
- When patients are prioritized through their affiliation with particular organizations.
- When patients are prioritized based on being deemed "very important people".
- When "two-tiered" healthcare systems allow patients quicker access to care when they are able to pay for service.

These themes are explored below.

4.1 *Socioeconomic Disparities*

Various studies in the academic literature attempt to answer the question of whether Canadians with higher socioeconomic status have greater access to doctors and healthcare service than Canadians with lower socioeconomic status.

It is important to note, as Chan & Austin (2003) explain, that these studies "cannot measure true access, defined as the ability to obtain an appropriate service given a health need, but do[es] examine utilization". That is, these studies are based on how individuals of varying social status and income levels use the Canadian healthcare system (after the fact); not, for example, how individuals with lesser status or means may be blocked from accessing the system (before the fact).

If the question is put forward as "Do Canadians with greater socioeconomic status have preferential access to healthcare?" or conversely "Do Canadians with lower socioeconomic status have a decreased ability to access healthcare?", researchers have drawn conclusions on either side of the debate.

4.1.1 *Studies that say "Yes"*

There are numerous studies that suggest that the Canadian healthcare system is similar to systems in the United States, United Kingdom, Spain and Sweden, where health services researchers have generated evidence that socioeconomic factors affect utilization of clinical services (Alter, Basinski, & Naylor 1998).

Alter and colleagues (1999) conducted a study on hospital admissions for Ontario residents who had experienced acute myocardial infarctions over a three-year period. The authors controlled for a number of variables (including patient age, sex, severity of disease, specialty of the attending physician, and characteristics of the hospital, among others) and inferred patients' income levels from the median incomes of their residential neighbourhoods according to the 1996 Canadian census. From their analyses, the researchers drew a number of conclusions, two of which were:

a) Those patients with myocardial infarction who lived in higher-income neighborhoods were significantly more likely to undergo treatment through angiography than patients in lower-income neighbourhoods.

b) Those patients with myocardial infarction who lived in higher-income neighbourhoods had shorter wait times for angiography than patients in lower-income neighborhoods.

Their conclusions suggest that the lower the median income level in the neighbourhood that the patient lived, the less likely the patient was to undergo treatment, and the longer the wait time was to receive treatment. Alter el al. (1999) write "although more affluent neighborhoods tended to have a greater concentration of specialized services, inequitable distribution of hospital resources did not account entirely for the effects of socioeconomic status on access to procedures and on outcome after acute myocardial infarction". In a follow-up commentary, David Alter suggests that managed waitlists "may be subjected to biases that will tend to favor the socially affluent or those who are best connected with either managing physicians or with the system itself" (2003).

Another study by Alter and colleagues (2004) backs up previous findings and adds another socioeconomic variable (education) to the equation. Data collected through telephone interviews with 2,256 patients, 30 days post-discharge from one of 53 hospitals across Ontario suggested that patients with higher incomes and higher education levels were significantly more likely to have been referred for coronary angiography, cardiac rehabilitation, and to a cardiologist than those with lower incomes and levels of education.

In another study focusing on access to specialist healthcare service, Haider and colleagues (2006) reported that the proportion of patients seeing a dermatologist (through referral) within two years of a diagnosis of a skin disorder increased from 17% in the lowest socioeconomic status category, to 24% in the highest socioeconomic category.

A study by Chan & Austin (2003) also suggests a "modest" positive correlation between preferential access to specialists and high-income earners. By accounting for the fact that individuals with low socioeconomic status have more illnesses, the authors proposed that high-income earners were receiving preferential access to specialist healthcare given their lower disease burden.

4.1.2 *Studies that say "No"*

For those studies above that suggest that those with higher socioeconomic status receive preferential access to healthcare, there are other studies that refute this conclusion.

Murray Finkelstein (2001) analyzed responses to a Canadian Population Health Survey for mean per capita expenditures on physician care and the probability of referral to a specialist, in relation to income and self-reported health status. After adjusting for health status (i.e., accounting for the fact that individuals of lower socioeconomic status have more illnesses), Finkelstein concluded that utilization of physicians' services was based on need, and *not* on income.

In a study by Pilote and colleagues (2007), the authors examined data from all patients admitted to acute care hospitals with acute myocardial infarction in three Canadian provinces over a five or six year period (n = 145,882). They found no associations between socioeconomic variables and access to cardiac medications or invasive cardiac procedures.

4.1.3 *Low Socioeconomic Status is Associated with Fewer Visits to Specialists*

McIssac, Goel & Naylor (1997) also did an analysis of an Ontario Health Survey for a possible association between socioeconomic status, need for medical care and the number of visits to general practitioners and specialists. In examining the responses of over 45,000 respondents

16 years of age or older, the researchers did not find an association between education or household income and the use of physician services (at least one visit per year). However, McIssac, Goel & Naylor (1997) did conclude that high income persons were *less* likely to have made six or more visits to a general practitioner in one year, and were *more* likely to have made at least one visit to a specialist, than low income persons.

Similar to McIssac, Goel & Naylor (1997), Veugelers & Yip (2003) studied survey data to evaluate whether universal healthcare coverage reduced socioeconomic disparities in health in Nova Scotia. Acknowledging their greater disease burden, Veugelers & Yip (2003) also found comparatively higher use of general practitioner services and lower use of specialist doctor services amongst those with a lower socioeconomic status.

4.2 *Waitlists*

When demand for services outstrips supply, a system must be created to allow fair access based on prioritization of the need for service. In terms of Canadian healthcare, the system involves wait listing. This section of the report looks at the literature that pertains to waitlists, and the factors involved in creating, managing and accessing waitlists that are subject to interventions that promote either preferential access or equitable improvements to access.

4.2.1 *The Existence of Waitlists*

Waitlists and wait listing are common topics in the healthcare literature. On the need for waitlists, Naylor (1991) suggests, "[d]elayed care with prioritization according to need is theoretically more equitable than overt denial of access on the basis of income or insurance coverage". Alter, Basinski & Naylor (1998) summarize the opposing viewpoints on waitlists, their existence in the healthcare system, and the idea of universally fair access to healthcare in Canada. One side points to them as impossible to manage fairly, and will suggest that as long as waitlists exist, the idea of universal access to healthcare itself is illusionary. On the other side of the argument, proponents say without them patients are not even in the system, and that waitlists are only created *after* a potential patient has accessed the system.

4.2.2 *The Existence of Queue Jumping*

Alter, Basinski & Naylor (1998) conducted a landmark survey to determine Ontario health care providers' perceptions and experiences of preferential access to cardiovascular services on the basis of factors other than clinical need. The study asked all practicing cardiologists, cardiac surgeons, and hospital chief executives, plus a random sample of internists and family practitioners (total 788 respondents) in Ontario about their beliefs towards, and experiences with preferential access. With their results, the authors sought to understand what "preferential access" actually meant to their study population.

Alter, Basinski & Naylor's (1998) most significant finding was that over 80% of responding physicians, and 53% of hospital chiefs admitted to have been personally involved in managing a patient who had received preferential access on the basis of factors other than medical need. Other significant observations from the study:

- More than 80% cited pressure from referring and consulting physicians, or patients and their relatives, as potential causes of preferential access.
- Eighty-eight percent indicated that personal connections to treating physicians were likely to play a role in preferential access.
- Factors that contributed to increased pressure to grant preferential access included knowledge of the risks of delayed care, and the patient's propensity to litigate.
- Seventy-one percent believed that preferential access came into play if the patient had community standing such that it would be advantageous to the hospital if the patient were pleased.
- Ninety-three percent agreed that preferential access was more likely granted to physicians and their families.
- Over 80% agreed that preferential access was more likely for public figures (entertainers, professional athletes, media members, politicians).
- In an area where write-ins were permitted, respondents also included patients enrolled in research protocols and patients

under intolerable stress due to waiting were taken into account in instances of preferential access.

4.2.3 *The Difficult Task of Managing Waitlists*

Alter, Basinski & Naylor's (1998) survey results and conclusions argue that preferential access is a real phenomenon. A few studies suggest why waitlist management is a difficult task. On the topic of why anyone should be concerned with organizing and managing waitlists, Lewis et al. (2000) writes "The main reason is fairness and equity … those with the greatest need for the intervention should be served first, if all else is equal. The probability that tens of thousands of individual, uncoordinated decisions, taken in a large, complex and diverse system will combine to yield fairness for all is vanishingly low".

Focusing on access to cardiac rehabilitation, Dafoe et al. (2006) suggest that failure to refer eligible patients, strength of endorsement for cardiac rehabilitation by physicians, lag time between cardiac event and referral, geographic issues, scheduling limitations, and capacity issues all contribute to the variation seen in waitlists for cardiac rehabilitation programs across Canada. The paper also suggests wait time benchmarks that may be considered standards for generating waitlists to reduce the disparities.

Lewis et al. (2000) were extremely critical in their paper on the state of waiting list information and management systems in Canada, describing them as "woefully inadequate". The paper argues that some factors that may be considered in managing a waitlist, including employment status, time on a waiting list and age are not scientific variables, making them difficult to argue for or against. Lewis and colleagues (2000) also discuss other variables that (could) go into managing wait lists and add to the difficulty of managing them: cost of the intervention, interest-group pressures, political perceptions of need, unstandardized concepts and terms, and the meaning and value of waiting time.

In Sanmartin and colleagues' (2000) paper, the authors suggest that another significant problem when considering waitlist management are differences in measurement approaches. One can find different interpretations of the same data for some fundamental aspects of waitlists, such as when a waiting list starts (e.g., first visit to family doctor? time when facility is booked?), how long waiting time actually

is, reporting statistics (e.g., mean waiting time? median? proportion waiting for a certain period?), and irregular auditing procedures.

4.3 *Disparities in the Referral Process*

Typically, access to specialist doctors and procedures occurs through primary care physicians, and the referral process. As referrals are received, specialists prioritize the incoming patient to place them on a waitlist based on the information coming from the referring physician.

The referral process is multi-faceted, with many variables for a family practitioner to consider before recommending a patient to a specialist (e.g., Can the patient be treated without seeing a specialist? How urgently is specialist attention required? Which specialist should be considered – the "best" with the long waitlist, or an unknown?). Making a referral also highlights the struggle between advocating for your patient versus proper use of the system (e.g., If I don't say this case is urgent, will my patient be made to wait longer?) (Van Rosendaal 2006).

The many variables involved make the referral process a non-standardized practice. Chan & Austin (2003) present a number of factors that influence specialist referral rates, each encompassing a range of values that change over time:

- patient-related factors – age, gender, socioeconomic status, expectations, need, demands.
- community type.
- specialist supply.
- physician-related factors – age, gender, training, workload, practice patterns, skill, confidence, time to assess patient.
- disease – presence, severity.

From the perspective of the specialist, gastroenterologist Van Rosendaal (2006) explains the difficulty of receiving referrals and prioritizing patients: "We regularly receive information regarding referred patients that overstates the severity of symptoms or that reports 'alarm symptoms' that are entirely absent on evaluation. Assessment of patients with less than urgent problems delays evaluation and treatment of patients with serious symptoms who truly require urgent care".

Even when a healthcare system attempts to formalize the system of scoring and ranking patients for referral the process can be undermined by some doctors circumventing the system. New Zealand created the "clinical priority assessment criteria (CPAC)" in an attempt to standardize waitlists for elective surgery across the country. Variation in the way CPAC were being used in score construction and in the influence of the score on access to surgery led the researcher to conclude that the tool "did not provide a transparent and equitable method of determining access to surgery" (McLeod et al. 2004).

4.4 *Professional Courtesy*

Professional courtesy is a custom with deep roots in medical practice, and is described as healthcare workers (primarily physicians) providing free or discounted service, and/or last-minute or after hours care, to other healthcare workers and their families (Levy et al. 1993). Originally intended so that physicians would not treat themselves or their own families, professional courtesy has been criticized as providing certain individuals with preferential access to healthcare (Bass & Wolfson 1980).

4.4.1 *The Evolution of Professional Courtesy*

A number of scholars point to the Hippocratic Oath as the root of professional courtesy, where it reads "I swear to reckon him who taught me the art equally dear to me as my parents, to share my substance with him and relieve his necessities as required; to regard his offspring as on the same footing with my own brothers, and to teach them this art if they should wish to learn it without fee or stipulation" (Bass & Wolfson 1980). In its first code of ethics, published in 1847, the American Medical Association included professional courtesy as an ethical obligation: "All practitioners of medicine, their wives, and their children while under the paternal care, are entitled to the gratuitous services of any one or more of the faculty residing near them, whose assistance may be desired" (although the current code does not mention it) (American Medical Association 1847; Levy et al. 1993).

In Canada, professional courtesy is a recognized practice that has been debated at provincial colleges and the Canadian Medical Association. With no resolution, the practice has been debated as being a custom, a tradition, or a moral imperative which should be enshrined in the Canadian Medical Association code of ethics (Goldman 1985). Levy et

al. (1993) suggest that, at least in the United States, medical associations have failed to provide physicians with proper guidelines for addressing this important issue.

4.4.2 *Opinions on Professional Courtesy*

A study by Levy and colleagues (1993), based on a survey of American Medical Association-listed physicians from 12 direct-care specialties, suggests that most physicians had a positive attitude toward professional courtesy:

- Over 90% of 2,224 respondents agree with the statement "I consider it an honor to care for other physicians".
- Just under 80% agreed that "professional courtesy solidifies bonds between physicians".
- Over 60% agreed that "giving professional courtesy is sound business practice".

4.5 *Preferential Access to Workers' Compensation Board*

DeCloet (1998) outlines the special circumstances where individuals eligible for Workers' Compensation (WC) in British Columbia can gain access to healthcare services such as surgery with shorter wait times than those not covered by WC. In British Columbia, the Workers' Compensation Board (WCB) pre-purchases surgery time from hospitals. WC claimants have their names put into prepaid spots on the waitlist for surgery. The practice is cited by the WCB as being cheaper than having patients draw compensation while waiting in the public system's queue. The WCB in British Columbia has even purchased services in neighbouring Alberta to meet the needs of its list of claimants. Critics of the practice suggest that if everyone is not eligible for these held and paid-for spots on treatment lists, it should be deemed preferential access.

4.6 *The VIP (Very Important Patient)*

As the case is put forward by Friedman, Schofield & Tirkos (2007), "the mayor, a visiting dignitary, or the spouse of a seven-figure benefactor is not commonly found waiting among the homeless and the intoxicated in the emergency department waiting room". Whether fair or not, there are instances when certain individuals are moved to the head of the queue due to their status or position, such as during the

assassination attempts of Ronald Reagan or Pope John Paul II (Smith & Shesser 1988). Smith & Shesser (1988) published a paper on handling (as they have termed it) the "Code Purple", outlining what measures should take place for the handing of VIPs, and how these measures may disrupt the normal process of care. These occurrences are often accepted to be "for the greater good", but when the interpretation of who is a "VIP" becomes questionable, attempts at this type of queue jumping become subject of complaint and are even cited as breaches of the Criminal Code (Cunningham et al. 2012).

4.7 *The Two-Tiered Care Debate*

The idea of preferential access to healthcare is inextricably tied to the concept of a two- or multi-tiered healthcare system, where those with means can "step out of the public queue" and pay for services at a private healthcare facility. Some have argued that the Canadian healthcare system cannot currently be considered a single-tiered system. For example the case of *Chaoulli v. Quebec*, that challenges the legality of prohibiting private medical insurance in the face of long wait times, brought the debate of the single-tiered system to national attention (Marchildon 2005).

Although a multi-tiered system must be acknowledged as a means by which preferential access to healthcare may be obtained, the topic is of such grand scale that it is considered beyond the scope of this review. The two- or multi-tiered system has been considered in various studies already cited in this report, and two instances are only cited here for this reason.

In Alter and colleagues' (2004) survey of acute myocardial infarction patients (referenced in Section 4.1.1 above), 20% stated that they favored allowing private care for anyone who was willing to pay. In addition when respondents were asked about their own willingness to pay for service, the proportion of those in favor of out-of-pocket payments for more expedient or a wider selection of treatment or hospital services increased to 25% (Alter et al. 2004).

In Friedman, Schofield & Tirkos' study (2007) (referenced in Sections 4.4.2 and 4.6), the authors note that legislation passed in Ontario in 2004 as Bill 8 sought to address instances of preferential access by stating that "the legislation closed legislative loopholes that allowed queue-jumping". Ontario, however, is just one jurisdiction in Canada.

Not all areas of the country have attempted to pass such legislation, leaving the possibility of queue jumping in other areas of Canada.

5. Is it Realistic to Eliminate Preferential Access?

Before presenting ways in which preferential access could be mitigated (below in Section 6), this portion of the review explores the opinions in the literature as to how difficult a task it might be. As this report describes, the incidences and opportunities for preferential access are myriad. There are a number of arguments in the literature that suggest that eliminating preferential access altogether may be virtually impossible. Chan & Austin (2003) suggest, "The small amount of preferential access for the socioeconomic elite is perhaps unavoidable, and on the whole, Canada's policy-makers may be reassured that their health care system is doing a reasonably good job at offering equitable access to care to all its citizens".

5.1 *The Problem of Finding the Evidence*

As stated at the beginning of this review, the scientific study-based literature gathering empirical evidence of preferential access to healthcare in Canada is limited. Even as the popular media highlight well-publicized incidents of individuals "jumping the queue", the academic literature does not provide any evidence-based proof of preferential access that might be targeted by anti-queue jumping measures. The studies cited that fit within the scope of this review are based on surveys, opinion and subjective data. At this point, it would be difficult to design and implement a means to limit preferential access that could be backed up with "before and after" and data to confirm the efficacy of the strategy.

5.2 *Patients Seeking Preferential Access*

Despite publicly upholding the values of a fair, equal and just healthcare system for all Canadians, being a patient in the system can change the perspective of some individuals. Patients and their families will go to new lengths to ensure timely care for themselves or their loved ones. As Friedman, Schofield & Tirkos (2007) write with respect to their findings from a survey of random households, "There was broad consensus for allowing people to jump ahead in queue for reasons of medical necessity, but not for reasons of status. When responding to questions relating to personal practice – both past and

hypothetical – participants, however, volunteered some readiness to undermine principles of accessibility".

In a survey given to 668 random households in the Toronto area, Friedman, Schofield & Tirkos (2007) reported that despite overwhelmingly advocating equal access based on need, approximately half of the total respondents (n = 101) surveyed "would call a friend who is a doctor, works for a doctor, or is a hospital administrator" to improve a position on a waiting list. In their Canadian study (outlined above in Section 4.1.1), Alter and colleagues (1999) found that almost 10% of the variation in patient waiting times was found to be explained not by clinical factors but by the hospital affiliation of the referring physician. Quoting Shortt's (1999) comments on the Alter et al study, "From the patient's point of view, 'who you know' turns out to be disconcertingly important" when accessing healthcare.

Using Friedman, Schofield & Tirkos' (2007) term, "undermining principles of accessibility" might also include threatening legal action (Alter, Basinski & Naylor 1998), taking advantage of high socioeconomic status (Alter 2003; Alter et al. 2004), or capitalizing on grey areas and jumping into prepaid spots on waiting lists (DeCloet 1998) to gain preferential access to healthcare.

5.3 *A Complex System with Many Access Points*

Healthcare in Canada is a multi-faceted, complex, and often non-standardized system that offers many points of entry for patients. Every province has its own healthcare insurance system and its own processes for patients to access and pay for service. It is hard to picture a legislation designed to limit or eliminate preferential access that would be applicable to every province and jurisdiction in Canada. Also, Cunningham et al. (2012) point out that the *Canada Health Act* (on which legislation might be based) relates to provincial health insurance plans and the general organization of insured services, not individual physician practice. Add to the problem of creating legislation: a) the number of ways a physician may run her/his practice, b) the options for diagnosing and referring a patient (Chan & Austin 2003), and c) the number of factors to be considered in prioritizing a patient for a waitlist (Shortt 1999; Lewis et al. 2000); there may be just too many holes to plug to eliminate preferential access.

5.4 *Is the Problem Worth Addressing?*

There are studies in the literature that question how much effort should be put into trying to eliminate preferential access, given that without empirical evidence the impact of the practice is unknown. In Lasser, Himmelstein & Woolhandler's (2006) study comparing access to care and health status in the United States versus Canada, the authors suggested that long waiting times led to an unmet health need for only a "small percentage" (3.5%) of Canadians. In the same article, the authors offer the opinion that perhaps "Canada's far lower health spending compromises aspects of care that affect satisfaction but not health outcomes" (Lasser, Himmelstein & Woolhandler 2006). Sanmartin et al. (2000) reported from their study that government respondents insisted that waiting-list problems are neither serious nor worsening, whereas all other respondents maintained the opposite. Unfortunately, both sentiments must be considered opinions without knowing the scope of the problem.

6. Strategies to Mitigate Preferential Access

Even as the previous Section of this review highlighted the fact that there is little empirical evidence of the impact of queue jumping, it is also a fact that preferential access to healthcare does occur. This portion of the review presents the strategies suggested in the academic literature that might be used to combat preferential access.

6.1 *Develop Ethical Guidelines*

Alter, Basinski & Naylor (1998), Van Rosendaal (2006) and Cunningham et al. (2012) make suggestions addressing medical ethics to address the problem of preferential access. Alter, Basinski & Naylor (1998) call for the development and implementation of "ethical guidelines that define and circumscribe preferential access". Van Rosendaal (2006) calls for physicians to "uphold the ethical principle of justice" in their work, reminding doctors that their responsibility is not limited to the individual patient, but extends to the population as a whole. Van Rosendaal's comments are with respect to physicians who provide inaccurate information in letters of referral sent to specialists, in order to prioritize the referring doctor's patient on a waitlist. Cunningham et al. (2012) offer their article "Ethics in Radiology: Wait Lists Queue Jumping" as a resource for educators to "stimulate discussion of ethical issues about wait lists and queue jumping with

residents", and offer their decision-making scenarios and framework as a resource for practicing radiologists interested in ethics.

6.2 *Educate, Inform, & Provide Feedback*

Education is offered as a basic strategy to limit preferential access. Alter, Basinski & Naylor (1998) suggest that medical students and postgrad trainees be taught generally about preferential access, while Van Rosendaal (2006) more specifically suggests that students learn how to better manage their practice with populations of patients in mind. Van Rosendaal (2006) also calls upon those who develop wait-list strategies to listen to feedback from the Canadian family physician – those practitioners who are most often the point of access to the healthcare system.

6.3 *Greater Transparency in the Referral Process*

The referral process (discussed in Section 4.3 above) largely falls under the prevue of the physician, not the patient. Specifically, the physician is often the sole decision-maker when deciding what specialist the patient will wait to see. Without the knowledge to make informed decisions, Lewis et al. (2000) note that "A patient may languish on a particular physician's waiting list for a long time without ever knowing that another physician could provide the needed service much sooner". Public information regarding the wait times for particular physicians able to provide the same treatment would remove the mystery from the referral process (Lewis et al. 2000). Patients may be less tempted to jump the queue if they know the queue is shorter somewhere else.

6.4 *Increase Healthcare Funding*

Although it may be the most controversial strategy, Alter, Basinski & Naylor (1998) do suggest that more generous funding for healthcare would speed up service, thereby reducing the temptation for patients to seek preferential access. More targeted spending, focusing on socially or geographically disadvantaged patients, may also decrease the temptation to queue jump (Alter, Basinski & Naylor 1998). Van Rosendaal (2006) encourages physician organizations to pressure governments to ensure that healthcare resources are sufficient.

6.5 *Develop Standards and Tools for Prioritization of Care*

Lewis et al. (2000) suggest that developing tools for a) the individual physician, to prioritize patients using consistent criteria within her/his practice; and b) groups of physicians to prioritize patients on pooled lists would lead to better waitlist management and fairer, standardized access to care. Van Rosendaal (2006) similarly calls for "effective and equitable" strategies to prioritize patients' access to care. MacLeod et al. (2004), however, have discussed how the implementation of just such a tool, namely the clinical priority assessment criteria for elective surgery across New Zealand, has been problematic (as discussed in Section 4.3 above).

Even before creating tools, Lewis et al. (2000) lament the dearth of good information systems based on standardized concepts and terms that may provide the data for prioritization tools. Sanmartin et al. (2000) join Lewis et al. (2000) in arguing that a universal (Canadian) definition of fundamental concepts, such as when a waiting list actually starts, needs to be established to be able to collect good data for information systems.

Finally, once waitlists are generated based on standardized data, tools and protocols, they must be managed properly. Lewis and colleagues (2000) argue that good management of waitlists:

- Would identify people at risk while subject to excessive waits.
- Would ensure that patients are reassessed when their condition changes.
- Would remove those whose clinical condition improves, who have decided to forgo the procedures, who die, who move out of the jurisdiction, etc.
- Should track outcomes to allow for continuous refinement of the criteria and weights used to prioritize patients.

Limitations of the Review

The literature on the topic of preferential access to healthcare in Canada may be subject to publication bias and researchers' reluctance to publish negative results. Also, a number of the significant studies referenced in this report are limited to a small number of authors, focusing on one area of healthcare – cardiovascular care. It is unclear as

to what extent their findings are generalizable to other health services. Finally, the author has interpreted studies from non-Canadian jurisdictions (particularly the United States) as applying to the Canadian context. These interpretations must be taken with the major differences in how healthcare is structured and delivered outside of Canada in mind.

Conclusions

Though there is no empirical, objective data on the impact of preferential access to healthcare in Canada, the practice does occur. Though not abundant, there are studies in the academic literature that examine how queue jumping may be facilitated by a healthcare system that provides better access to those with greater socioeconomic means. There is also research on the non-standardized systems that are used for generating and maintaining waitlists, or processing referrals to specialists that can create opportunities for preferential access. There are the special circumstances surrounding professional courtesy, Workers' Compensation claims, and "very important patients" that are deemed by other researchers as examples of preferential access. Finally, there are various jurisdictions in Canada that permit individuals to "step out of the public queue" and pay for healthcare services at private facilities with shorter wait times.

While some investigators question whether it is even advisable to try and address preferential access, there are others who suggest that there are educational, legislative and functional strategies that can help mitigate the practice.

Like the Canadian healthcare system itself, preferential access is a complex topic. Academic research in the fields of medicine, law, business and sociology must continue in order for us to grow our understanding of what impact preferential access has on Canadian society, and how we might reduce that impact in the future.

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Renal Dialysis Rimbey Support Group Report

Dr. John Church

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4. Renal Dialysis Rimbey Support Group Report

Dr. John Church

Executive Summary

Rimbey and Area Dialysis Support Group Submission to the Alberta Health Services Preferential Access Inquiry

As part of the Alberta Health Services Preferential Access Inquiry, the Rimbey and Area Dialysis Support Group were asked to make a formal written submission. The written submission focuses on the financial, safety and health costs associated with travelling to Red Deer to receive dialysis services. The formal submission will be presented to the Inquiry in Calgary on February 27, 2013.

Rural Canada

Research and government reports on rural health care over the past two decades have emphasized a growing gap between Canadian rural and urban communities when accessing healthcare services. In addition to enjoying poorer health status and facing increased health risks, rural Canadians are confronted with a healthcare system that is not designed to serve their needs. In a nutshell, urban Canadians receive preferential access to health care.

Alberta's Rural Development Strategy

Announced in 2005, A Place to Grow, Alberta's Rural Development Strategy, committed the provincial government to strive to: ensure that people in rural Alberta have access to quality public services; and, adapt and adjust programs and measures to take into account the unique aspects of rural communities. Included in this strategy is making sure people in rural Alberta have access to quality health services, recognizing the role rural health regions can play in health renewal, and providing opportunities to develop the economic potential of health care services.

Alberta Health Services

Alberta Health Services is responsible for the delivery of health services to all Albertans according to the following guiding principles: local leadership and decision-making; focusing and fine-tuning our efforts to see the health system through the eyes of patients and communities; eliminating bureaucracy; and, valuing, trusting and respecting our staff, physicians and volunteers. Currently, Alberta Health Services has developed options for bringing dialysis services to rural communities. So far, they have refused to consider these options for Rimbey despite requests from local leaders.

The Rimbey Situation

Rimbey residents' costs are five times as much to access the same dialysis services as residents living in Red Deer. They travel over 1000 hours per month, use their own vehicles for transportation, and travel on statistically dangerous highways. Collision rates on these highways are 60 percent above the provincial average. In the last several years, one patient has been killed, one has been seriously injured and others have had near misses while driving back and forth between Rimbey and Red Deer. Rimbey residents are literally risking their lives to access dialysis services in Red Deer. Other rural Alberta communities are facing similar challenges. Meanwhile, dialysis patients in urban centres, such as Red Deer, have access to subsidized public transit options that provide door-to-door transportation and some of the largest urban areas in Alberta are provided with convenient access to services in neighbourhood shopping centres.

The Rimbey group has been trying for five years to get Alberta Health Services to recognize the life threatening challenges to accessing dialysis services that they face. While Alberta Health Services has refused to bring dialysis services into the community, Rimbey has a relatively new hospital that could accommodate a dialysis unit. Medical and nursing staff who currently provide dialysis services in Red Deer have indicated that they could support a dialysis unit in Rimbey. Other options, such as mobile dialysis and storefront services currently being used by Alberta Health Services, might also be used to bring dialysis services to Rimbey.

Recommendations

1. In partnership with the Rimbey and Area Renal Dialysis Support Group, Alberta Health Services and the Northern Alberta Renal Program develop a detailed case illustrating costs/benefits for all options available to Rimbey and area renal dialysis patients, consistent with the principals of the CHA, the Alberta Health Services mission "to provide a patient-focused, quality health system that is accessible and sustainable for all Albertans" and the goals and objectives of the Alberta rural development strategy.
2. In partnership with the Rimbey and Area Renal Dialysis Support Group, and other rural communities, Alberta Health Services and the Northern Alberta Renal Program, establish strategies to address effectively and equitably the needs of rural dialysis patients in Rimbey and other rural communities in Alberta.
3. In partnership with the Rimbey and Area Renal Dialysis Support Group, and other rural communities, Alberta Health Services and the Northern Alberta Renal Program, ensure public availability of relevant information and transparency in decision-making and resource allocation for dialysis services. Albertans want to know how decisions are being made, and that decisions are open and fair. Involving rural communities in a meaningful way and carefully considering their quality of life when making decisions about their health and the health care services they receive is a key part of a patient-focused approach to health care.

Background

On October 11, 2012, Rimbey and Area Renal Dialysis Support Group submitted a request to Mr. Justice John Z. Vertes, Commissioner of the Health Services Preferential Access Inquiry called by the Province of Alberta, asking for an opportunity to make an appearance at the Inquiry to present a request for funding to support appearance at the Inquiry. On November 7, 2012 we made an oral submission to the Inquiry and subsequently were advised that we should more formally document our concerns and submit this to the Inquiry. We wish to express our appreciation for being given the privilege of appearing on October 11,

and respectfully present the submission of the Rimbey and Area Renal Dialysis Support Group.

Canada Health Act

Section 3 of the *Canada Health Act* states that "the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada" [*Canada Health Act*, RSC 1985]. The *Canada Health Act* deals with how hospital and physician services are funded, and leaves how services are to be delivered to the provinces and territories. However, the Act does "seek to ensure that Canadians have universal and reasonable access on uniform terms and conditions to a range of physician and hospital services on the basis of need and without regard to individual ability to pay."[1] "Therefore, to the significant degree that relative access to these services would otherwise depend on each person's financial capacity, Medicare seeks to ensure equality of access to the health services it encompasses."[2] It is understood that for practical reasons a service may be more available in some areas than others, resulting in some variation in access including variation between people who live in rural and urban communities. However, under the universality criterion, the rationale is to ensure general equality of access to the services funded by a health care plan on uniform terms and conditions. In conjunction with the universality criterion, the accessibility criterion repeats the requirement for uniform terms and condition, and adds that access must also be "reasonable". While reasonableness has not been defined, referring to the overall objective of health care policy to promote and restore physical and mental wellbeing of residents of Canada, rural residents face an additional burden when attempting to access healthcare services under uniform terms and conditions. In the case of access to dialysis services in Alberta, rural residents can face significantly greater financial barriers than urban residents when attempting to access the same services. The *Canada Health Act* was designed to ensure that Canadians had equitable access to services, that is, that Canadians with the same medical condition, needing to access the same medical service would have comparable access to these services without financial barriers. Clearly, in the case presented below,

[1] Lahey, W. The Legislative Framework Governing Access to Health Services that are "Insured Health Services" under the *Canada Health Act* and "Insured Services" under the Legislation of Alberta, A Report to the Health Service Preferential Access Inquiry of the Province of Alberta, November 2012, p.4 .
[2] *Ibid*, p.8.

Rimbey and area dialysis patients do not have comparable access to medically necessary services without financial barriers. In addition, they face life-threatening transportation barriers. Comparable patients in urban settings are not faced with comparable costs or transportation safety barriers and appear to enjoy preferential access to publicly funded dialysis services.

Rural Health Care in Canada

Rural Canada is diverse both geographically and economically. Rural communities are unique in their characteristics, values and employment. In Alberta, rural economies may include activities related to agriculture, oil and gas, forestry, mining, and tourism. A number of reports in Canada have identified issues related to the health care of rural Canadians.[3] [4] [5] [6]

- Canada may have a good health care system with good health outcomes, but this is not the reality for Canadians living in smaller or more isolated communities. Canadians living in rural and remote communities spoke to the Commission on the Future of Health Care in Canada (the Romanow Commission) of the need for good health and good access to health care because it is essential not only to sustain their own quality of life, but the quality of life in their communities.
- The health status of rural residents is lower than urban residents. Rural residents have lower health status than urban residents, higher overall mortality rates and shorter life expectancies, as well as higher rates of long-term disability and chronic illness. Rural Canadians are limited to a smaller range of health providers. The most serious problem for residents of rural and remote areas is access to

[3] The Future of Rural Healthcare (2001). Society of Rural Physicians of Canada, Submission to The Commission on the Future of Health Care in Canada. http://www.srpc.ca/PDF/srpc-submission.pdf.
[4] Building on Values: The Future of Health Care in Canada, Final Report, Commission on the Future of Health Care in Canada, Government of Canada, November 2002, Chapter 7. http://publications.gc.ca/collections/Collection/CP32-85-2002E.pdf.
[5] Rural Canada: Access to Health Care (2002). Ottawa: Economics Division. 23 p. 4,6. http://publications.gc.ca/Collection-R/LoPBdP/BP/prb0245-e.htm.
[6] Government of Canada (October 2002). Senate Standing Committee on Social Affairs, Science and Technology. The Health of Canadians: The Federal Role. http://www .parl.gc.ca/Content /SEN/Committee/372/soci/rep/repoct02vo16-e.htm.

the health care services they need closer to their own communities. The chronically ill and infirm elderly are at particular risk and often have to move away from their friends, families and homes. Rural seniors play a significant role in sustaining rural communities. They populate volunteer groups that provide many valuable services for rural communities. They also provide support for younger working parents who may have few options for childcare in rural settings. When forced to move away, not only is this community capacity lost, the capacity and health of the individuals may be negatively affected by being separated from their communities and their families.

- If rural residents require more specialized care they must travel longer distances and incur additional expenses that are not fully reimbursed. During some parts of the year, travel may be impossible due to weather conditions leading to poor health outcomes.
- One of the biggest barriers is the organization of the health care system "in a highly centralised manner better suited to countries with dense populations and short distances."[7]
- "When centralised policies do not fit rural realities, as they so often do not, the rural side is swept under the carpet."[8] The centralization of health services and rural hospital closures has had a severe impact on rural residents. Widespread closure of rural hospitals in some provinces has had serious consequences for local residents.
- Urban planning has dominated the planning of rural health care programs, to the detriment of rural populations. The predominance of urban approaches meets the needs of large hospitals in major urban centres, but doesn't meet the needs of rural communities.
- Primary care reform is the mantra of health care analysts and consultants. It is perceived as "in the box" thinking.

[7] The Future of Rural Healthcare, Society of Rural Physicians of Canada, Submission to The Commission on the Future of Health Care in Canada, p.8. http://www.srpc.ca/PDF/srpc-submission.pdf.

[8] The Future of Rural Healthcare, Society of Rural Physicians of Canada, Submission to The Commission on the Future of Health Care in Canada p.8. http://www.srpc.ca/PDF/srpc-submission.pdf.

"Few have understood that it is hard to put the round peg of rural health into that box."[9] The concept of primary and specialist care reflects a division of labour that occurs in the big cities. In rural areas, specialist care is often non-existent. To receive such care, patients often must travel significant distances on a frequent basis at their own expense. Even access to primary care can be limited because of shortages of family physicians in rural areas.

- As seniors get older, their cognitive abilities may diminish. Eventually, many will have their driving privileges reduced or eliminated completely. As the population ages, younger seniors (65-80) increasingly may be driving older seniors (>85), or spouses may be co-pilots when travelling to medical appointments. Public transportation options in rural areas are limited or non-existent. Seniors who must travel into urban centres for medical appointments have fewer options than seniors in urban centres.

In their submission to the Romanow Commission, the Society of Rural Physicians of Canada in discussing barriers to change concluded, "what is needed in general, in our opinion, is for rural health care to be treated not as a difficult child of the present system, but as a distinct entity, with its own specific challenges and solutions."[10] As was identified over a decade ago by Dr. John Wooton, "if there is two-tiered medicine in Canada, it's not rich and poor, it's urban versus rural."[11]

Alberta's Rural Development Strategy

A Place to Grow, Alberta's Rural Development Strategy developed in 2005, committed the provincial government to strive to:

- Ensure that people in rural Alberta have access to quality public services.
- Adapt and adjust programs and measures to take into account the unique aspects of rural communities.

[9] *Ibid.,* p.5.
[10] *Ibid.,* p.9.
[11] Dr. John Wooton, "New Office to Focus on Rural Health Issues," *Farm Family Health*, Vol. 7, No. 1, Spring 1999.

- Encourage innovation in rural Alberta and promote innovative and creative solutions to the current challenges in rural Alberta.
- Foster learning in rural Alberta by making sure new opportunities are available for rural Albertans to learn, adapt and develop new knowledge and skills essential for economic development.
- Promote and expand rural Alberta's vital role in Alberta's competitive advantage in the global marketplace.
- Make rural Alberta a key part of the appeal that makes our province the best place to live, work and visit.

The Strategy outlines objectives and actions to be taken to strengthen and sustain rural communities, including:

- **Community capacity, quality of life and infrastructure** – ensuring that rural communities have the capacity, the quality of life, and the infrastructure necessary to remain vibrant and attractive places to live, work and visit.
- **Health care** – making sure people in rural Alberta have access to quality health services, recognizing the role rural health regions can play in health renewal, and providing opportunities to develop the economic potential of health care services.

Priority actions identified included:

- **Building community capacity.**
- **Improving access to health care:** "Steps will be taken to make better use of the capacity in rural hospitals and health regions to improve access for people in rural and urban communities and to build the economic potential of health services in rural communities."

The economic potential alluded to in the Alberta Rural Development Strategy refers to the traditional role of hospitals in rural communities as a source of employment and income for local communities. The presence of hospital services is also a draw for new commercial and

industrial development. While this presence was diminished when regional health boards were introduced, the development of new hospital facilities in rural communities such as Rimbey has created new opportunities for economic growth.

As identified in Alberta's Rural Development Strategy, rural communities tend to have a higher proportion of seniors. While not all renal dialysis patients are seniors, most are in the adult population, individuals who play important roles in rural communities providing support to families and friends, volunteering in community activities and projects, and sharing their talents with their communities. These individuals have a strong attachment to their communities and would prefer to continue living in their communities as they age, helping to preserve the rural way of life, instead of having to move to an urban centre.

If rural patients cannot gain adequate access to non-emergent and frequently required healthcare services such as renal dialysis they face the prospect of having to sell their homes and move to an urban centre, as has been the case for numerous rural families. Having to leave their communities and community networks imposes not only a financial cost, but also a social cost on individuals, their families, their friends and their community. In cases where one partner dies after relocation to an urban setting, the other partner is often isolated because of lost connections to their rural community.

Alberta rural communities are also deprived of the social capital that these individuals bring through their knowledge and skills. In the case of the Town of Rimbey, over 500 seniors contribute to voluntary organizations including local churches, school lunch programs, the library, the museum, the seniors centre and the handi-van.

Patient-Centred Care

In recent years, the concept of patient-centred care has begun to reshape health care. The Canadian Medical Association, the Canadian College of Physicians and Surgeons and provincial/territorial governments have all embraced the concept.[12] [13] [14] [15] [16] [17] At its

[12] Canadian Medical Association (2007), Putting Patients First®: Patient-Centred Collaborative Care A Discussion Paper. http://fhs.mcmaster.ca/surgery/documents/CollaborativeCareBackgrounderRevised.pdf.

essence, patient-centred care means focusing on the needs and preferences of patients rather than the needs and preferences of health providers or health organizations. Thus, designing health service delivery based on provider preferences and centralized urban planning models may not be appropriate for serving rural populations. In fact it may reflect decisions that focus on the needs of health managers and providers (system-centric) rather than patients.

Alberta Health Services

The mission of Alberta Health Services (AHS) is to provide a patient-focused, quality health system that is accessible and sustainable for all Albertans. AHS is responsible for the delivery of health services to all Albertans according to the following guiding principles:

- Local leadership and decision-making.
- Focusing and fine-tuning our efforts to see the health system through the eyes of patients and communities.
- Eliminating bureaucracy.
- Valuing, trusting and respecting our staff, physicians and volunteers.[18]

Kidney Disease and Diabetes in Alberta

Nearly 38,000 Canadians were living with kidney failure in 2009 – more than triple the number (11,000) living with the disease in 1990.[19]

[13] College of Family Physicians of Canada (2009). Patient-Centred Primary Care in Canada: Bring It On Home. Discussion Paper. http://www.cfpc.ca/uploadedFiles/Resources/Resource_ltems/Bring20it20on20Home20FINAL20ENGLISH.pdf.
[14] Patients' Association of Canada. What Patient Centred Care Really Means. http://patientsassociation.ca/video/don-berwick-what-patient-centred-care-really-means.
[15] Government of British Columbia, A New Era for Patient-Centred Health Care. http://www.health.gov.bc.ca/socsec/pdf/new_era_sustain.pdf.
[16] Government of Saskatchewan. Patient and Family Centred Care. http://www.health.gov.sk.ca/pfcc.
[17] Focus on patient-centred care highlights need for reforms. Globe and Mail. Nov 9, 2011. http://www.theglobeandmail.com/partners/focus-on-patient-centred-care-highlights-need-for -reforms/article4252728/.
[18] AHS (2012). Fine-Tuning Alberta's Health System. http://www.albertahealthservices.ca/7502.asp.
[19] Alberta Health Services (2012). Local renal program marks 50th anniversary of milestone. December 19, 2012. http://www.albertahealthservices.ca/7746.asp.

Kidney diseases can occur for a variety of reasons including: infections, such as polycystic kidney disease (an inherited genetic disorder), pyelonephritis, and glomerulonephritis (inflammation of blood vessels), or a kidney problem you were born with; a narrowed or blocked renal artery (carries blood to the kidneys); long-term use of medicines that can damage the kidneys e.g. non-steroidal anti-inflammatory drugs (NSAIDs), such as Advil and Celebrex. Diabetes and high blood pressure are also common causes of chronic kidney disease.[20]

Diabetes is a chronic disease that is "a large and growing problem in Alberta."[21] Over the past two decades the number of Albertans with diabetes has increased 2.5 times. "Diabetes is most prevalent in the aging population, who tend to have additional health problems that subsequently increase the burden on Alberta's health care system."[22] Many individuals with diabetes go on to develop kidney disease.

Patients who are diagnosed with diabetes require ongoing and long-term treatment. In 2009, the incidence of diabetes (number of new cases) identified in Alberta was more than double the incidence in 1995. Albertans with diabetes are twice as likely to die annually as those without diabetes.

In 2009, the rate of End Stage Renal Disease (ESRD) in Alberta was 12 times greater in patients with diabetes. Between 1997 and 2007, the number of patients with end-stage renal disease for diabetes patients increased from 39 percent to 56 percent. Diabetes patients over the age of 75 are most likely to develop ESRD and are increasing at the greatest rate.[23]

[20] Government of Alberta (2013). Health Information and Tools: Health A-Z. https://myhealth.alberta.ca/Pages/default.aspx.
[21] Johnson, J.A. and Balko, S.U. (2011). "Epidemiological Trends of Diabetes in Alberta" (Chapter 2). Alberta Diabetes Atlas 2011, 13. http://www.albertadiabetes.ca/documents/AtlasWeb.pdf.
[22] Johnson, J.A. and Balko, S.U. (2011). "Epidemiological Trends of Diabetes in Alberta" (Chapter 2).Alberta Diabetes Atlas 2011, 13. http://www.albertadiabetes.ca/documents/AtlasWeb.pdf.
[23] Klarenbach, S. et al. (2011). "Diabetes and Kidney Disease in Alberta" (Chapter 8). Alberta Diabetes Atlas. http://www.albertadiabetes.ca/documents/AtlasWeb.pdf.

Options for Treatment of ESRD (End Stage Renal Disease)[24]

A variety of options have been developed for the treatment of ESRD. However, many of these options are not feasible for all patients, especially those who have diminished physical or cognitive capacity due to aging and those with complex health issues.

Hemodialysis: Hemodialysis is a process used to clean and filter the blood to remove harmful wastes and extra salt and fluids. It also filters out excess potassium, sodium and chloride. This filtering or cleansing process is what a healthy kidney would normally do. Hemodialysis uses a mechanical filter, a dialyzer, to clean the blood. This connects to a machine through which the blood travels by IV tube during treatment. Once the blood passes through the machine and is cleaned, it flows back into the body through an IV tube. Most people require three 4-hour treatments every week. Patients must be under the care of a Nephrologist (kidney specialist) to undergo hemodialysis. Referral to a Nephrologist is through a General Practitioner or an Emergency Room. Hemodialysis can be done either at home or at a location outside of the home. Home dialysis requires the participation of a second individual to assist the patient and requires special training. When performed outside the home, hemodialysis involves trained professionals such as nurses and doctors. The possible complications associated with rapid changes in the body's fluid and chemical balance during treatment include: muscle cramps and hypotension. Hypotension, which is a sudden drop in blood pressure, can cause feelings of weakness, dizziness, nausea or death.

Home Dialysis: This form of hemodialysis often requires home renovations to accommodate the storing of equipment and supplies. A specific physical layout is required to accommodate the treatment. As mentioned above, a friend or family member, or hired aide is required to assist with home dialysis. Both the patient and the friend/family member/aide require specialized training. This training requires the patient and their assistant to relocate at their own expense to Edmonton for a period of six weeks. Driving back and forth every day for six weeks is just not feasible. The benefits of home dialysis are: an increased sense of control and independence; avoidance of travel associated with treatment; and, treatment during hours that are

[24] Kostadarus. A. "End-Stage Renal Disease: Choosing a treatment that is right for you." http://www.kidneydoctor.com/esrd.htm.

convenient to the patient. The challenges associated with home dialysis include: the cost and inconvenience of retrofitting existing space; the stress placed on friends/family members; the additional training; and the distance from trained medical personnel in the event of an emergency.

Hemodialysis Outside of the Home: This form of dialysis might take place in several locations: health facility; specially equipped mobile facility (bus); or a specially equipped, storefront facility. What all of these options have in common is that there are trained medical personnel on hand to administer treatment and that the patient must travel outside of the home to receive the treatment. The benefits of receiving treatment in these settings include: presence of trained medical professionals; and, interaction with other patients.

The challenges of receiving treatment in these settings include: travelling outside of the home for treatment; and lack of control over the schedule.

Peritoneal Dialysis: This form of dialysis uses the lining of the abdomen to filter impurities from the blood. A cleansing solution (dialysate) travels through an IV tube to the abdomen. Various fluids and waste pass through the blood vessels of the abdomen and into the dialysate. After several hours, the dialysate is drained from the abdomen taking the impurities with it. New dialysate is pumped into the abdomen and the process is repeated. This process may occur either with or without a machine.

Continuous Ambulatory Peritoneal Dialysis (CAPD), when performed without a machine, the patient has an external plastic bag attached to a catheter inserted in the abdomen. After several hours the solution is drained from the abdomen back into the bag and the bag is emptied. New dialysate is then placed in the bag and reintroduced into the abdominal wall. While being worn, the bag is hidden underneath clothing. The process is repeated three to four times a day. The benefit of this form of treatment is that it does not require a partner to assist. Possible complications to this form of treatment include: infection where the catheter is inserted into the abdomen; problems connecting and disconnecting the bag; and, fever and stomach pain.

Continuous Cyclic Peritoneal Dialysis (CCPD) uses a machine to fill and drain the dialysate. The process can occur at night while the patient is sleeping and takes 10-12 hours.

Intermittent Peritoneal Dialysis (IPD) uses the same machine as CCPD. While it can be done at home, it usually takes place in a health care facility and takes longer than CCPD. As with CAPD, infection at the catheter insertion point is a potential complication.

Kidney Transplant: Ultimately, replacement of the diseased kidney with a healthy kidney is desirable. In order for this to occur, a compatible donor kidney must be found. This might come from a living or deceased donor. The current demand for kidneys for transplantation significantly exceeds availability across Canada.

Possible complications from this procedure include rejection by the body of the new kidney. Anti-rejection drugs are used to reduce the chances of rejection. Kidneys from living relatives are less likely to be rejected than kidneys from unrelated cadavers. Long-term use of anti-rejection drugs can cause liver and kidney damage.

Access Barriers to Renal Dialysis Services for Rural Alberta Residents

The Northern Alberta Renal Program now helps more than 1,100 patients at 22 sites in the central and northern parts of the province.[25] However, residents of rural communities who require regular and frequent access to renal dialysis are not having their needs provided for under the same terms as urban patients. For example, patients of Rimbey and nearby centres must travel to Red Deer, three times a week, a 170 km round trip each time they require a dialysis treatment. Other rural Alberta communities such as Lac La Biche face similar challenges. At certain times during the winter, adverse weather conditions require the closure of rural primary and secondary roads.[26]

[25] U of A hospital marks 50th anniversary of first dialysis. http://www.cbc.ca/news/canada/edmonton/story/2012/12/19/edmonton-dialysis-50th-anniversary-university-alberta.html?cmp=rss&utm_source=dlvr.it&utm_medium=twitter.
[26] Emily Mertz. "Lac La Biche dialysis patients demanding better health care." Global Edmonton. Friday, August 24, 2012. http://www.globaltvedmonton.com/lac+la+biche+dialysis+patients+demanding+better+health+care/6442703037/story.html.

The impact of geography and transportation of patients in rural areas creates barriers (including significant health risks) and impedes access to needed health services. In addition to the burden of travelling for treatment, Rimbey and area patients can sometimes be diverted from Red Deer to other facilities like Rocky Mountain House or Wetaskiwin when patient volumes in Red Deer reach capacity, creating further disruption in their lives.

Transportation is vital for access to health services, particularly in rural areas where distances are greater, road conditions can be highly variable, and access to alternative modes of transportation is less prevalent and significantly more expensive. Regardless of weather or road conditions, patients requiring renal dialysis must make the journey – foregoing such treatments is not an option.

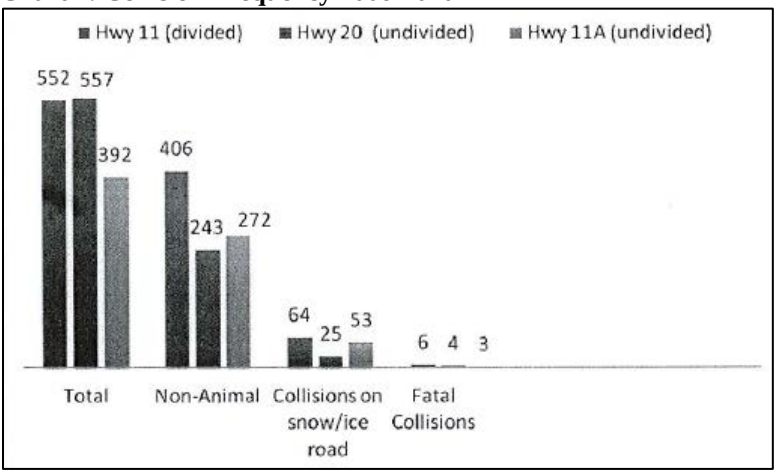
Rural patients carry not only the burden of their condition but also the material, physical, emotional and financial stress of having to travel longer distances on hazardous roads to access treatment on a very frequent basis, a burden experienced to a much lesser degree by urban residents accessing the same services.

Transportation Accident Risk

According to Alberta Transportation, "the majority of fatal crashes (69.8%) occurred in rural Alberta" between 2006 and 2010, although the number of vehicle accidents increased by 2 percent during 2009-2010 period.[27] [28] [29] [30] [31] During this period, a total of 13 fatal vehicle accidents occurred on the highways in and around Rimbey (Chart 1). It is these highways that Rimbey dialysis patients must use to access dialysis services in Red Deer three or four times per week.

[27] Alberta Transportation. Alberta Collision Statistics, 2006. http://www.transportation.alberta.ca/Content/docType47/Production/2006AR.pdf.
[28] Alberta Transportation. Alberta Collision Statistics, 2007. http://www.transportation.alberta.ca/Content/docType47/Production/2007AR.pdf.
[29] Alberta Transportation. Alberta Collision Statistics, 2008. http://www.transportation.alberta.ca/Content/docType47/Production/2008AR.pdf.
[30] Alberta Transportation. Alberta Collision Statistics, 2009. http://www.transportation.alberta.ca/Content/docType47/Production/2009AR.pdf.
[31] Alberta Transportation. Alberta Collision Statistics, 2010. http://www.transportation.alberta.ca/Content/docType47/Production/AR2010.pdf.

Chart 1: Collision Frequency 2006-2010



Source: Alberta Transportation, Personal Correspondence, November 27, 2012.

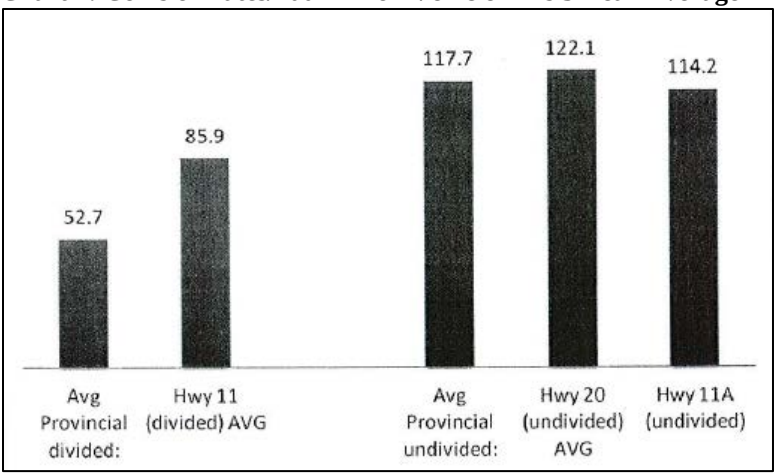
One of these deaths involved a patient returning to Rimbey after dialysis treatment in Red Deer. An elderly lady driving home after a long day for dialysis treatment in Red Deer had an accident. Complications from her weakened condition contributed to her death. Her son, who also requires dialysis, faces problems getting to Red Deer as his father now has to close his business four times a week to run his son into Red Deer for treatment. Thus, family members and friends who assist rural dialysis patients often pay a financial cost as well as suffer a personal loss (See Attachment 1).

A second patient was in a non-fatal accident that resulted in a broken hip and an extended (four month) stay in hospital. This cost the health care system $193,320. Following this accident, he was no longer able to drive to Red Deer and he and his wife ended up leaving their home by Rimbey and moving to Red Deer, leaving the community where they had lived for many years.[32] As previously discussed, relocating to an urban setting in these circumstances often leads to social isolation and declining quality of life.

[32] Alberta Health, Personal Correspondence, November 22, 2012.

Many have travelled at numerous times during the winter months when people were being advised not to travel on the roads. Travel was "not recommended" but they had to take chances.

Chart 2: Collision rates/100 Million Vehicle Kms 5 Year Average



Source: Alberta Transportation, Personal Correspondence, November 27, 2012.

As Chart 2 indicates, the collision rate on Highway 11 between 2006 and 2010 was 60 percent above the provincial average. The collision rate on Highway 20 was above the provincial average during this time period. Both highways are subject to high traffic volumes associated with the oilfield servicing industry, agriculture and seasonal tourism.

Table 1: Typical Dialysis Patient Day

	Rural Patient (Rimbey and Area Patients)	**Urban Patient (Red Deer Patients)**
Time Commitment	10 hours per treatment	6 hours (5 hours in hospital)
Human Resources	Rural patients ***should*** be accompanied by a second individual to treatments to act as a driver	Urban patients do not have this requirement if they access the Transit Action Bus or other local public transit
Transportation (Extra KM on average per year)	Distance: 300 KM/week x 4 = 1,200/month x 12 = 14,400/KM extra per year Personal vehicle with driver (20 hours x 3 times/week x 4 times/month x l2 times/year = 2880 hours.	Extra Distance: N/A Personal vehicle, or Handi-Bus, taxi, or city bus
Average Extra Costs / Year	Vehicle wear-and-tear: Other vehicle expenses - $1,800/yr (estimate)	Handi-Bus: 3 trips/week x 4 @ $35/month x 12 months = $420 Taxi: variable Srs. City bus: $56/month x 12 = $672

	Gas: ($85/fill x 5 fills per month @ 3 trips/week = $425/month x l2 = $5,100/year) With 75% for dialysis use = $3,825 Parking: $33/month x 12 = $396/year Travel cost: $5,625/year Meals: 2 people x $8.50 = $17.00 x 2 per trip = $34/day and 3 days/week = $102/week = $408/month x 12 months = $4,896/year Cost to required driver: If working, three full days of lost wages per week. **Total: $10,521 (average estimate)**	Gas: N/A - not on ongoing basis Parking: when being dropped off. Meals: N/A as can eat at home both before and after treatment or 1 x $8.50 x 3 x 4 x 12 = $1,224 Cost to required driver: If working two hours per day for 3 days of lost wages, or none if dialysis occurs in the evenings. **Total: $1,896 (estimate)**
Travel Risks	Rural driving conditions and associated traffic fatality rate	N/A

A Typical Dialysis Patient Day

A typical patient day for a Rimbey and area dialysis patient (Table 1) lasts approximately 10 hours. This includes between 4–6 hours of treatment, plus 2 hours travel time and 2 hours for preparation and meals. As the information provided in the preceding charts on transportation indicates, driving the roads between Rimbey and Red Deer involves a risk that is well above the provincial average. In fact, as described above, patients have been involved in serious accidents resulting in significant injury and death as a result of driving to Red Deer to receive dialysis treatment. In addition to the significant transportation risk experienced by Rimbey and area dialysis patients en route to and from treatment in Red Deer, Rimbey and area patients also experience significant financial costs compared to Red Deer patients receiving the same care at the same AHS facility. Table 1 (previous page) compares the various direct costs to Rimbey and area patients compared to patients living in Red Deer. Rimbey and area dialysis patients pay at least five times as much in out-of-pocket expenses as comparable patients living in Red Deer.

Options for Treatment for Alberta Rural Dialysis Patients

In-Centre Dialysis

The current option for dialysis patients from Rimbey and surrounding communities is to travel to Red Deer three times a week for dialysis treatments at the Red Deer Hospital, a 170 km round trip each time. A typical trip includes 4-6 hours of treatment, plus time for travel, preparation and meals (10 hours/day average). As previously discussed, driving the roads between Rimbey and Red Deer involves a demonstrated risk of accidents and adverse weather conditions that impose a burden in addition to a patient's medical condition. Patients experience significant financial costs, which are not reimbursable, in addition to the impact on family, friends or volunteers who must accompany them to treatments.

The Rimbey and Area Renal Dialysis Support Group has been trying for five years to get a dialysis unit in the Rimbey Hospital and Care Centre that was opened three years ago. The Rimbey Hospital and Care Centre has a 23 bed Acute Care Medical Unit and an 11 bed Emergency Department. The Seniors Health Care Centre has 84 beds. Rimbey can accommodate improved service and it would benefit area

patients financially and eliminate much of the danger, stress and cost associated with the constant travel to and from Red Deer. By offering this service, the community would be using the health facility in an efficient way, and it would lessen the load on the Red Deer Hospital and other treatment centres.

Providing the service in the Rimbey Hospital would also fit with the priority actions of the Alberta Rural Development Strategy (described above). Dr. Kym Jim, who is a nephrologist in Red Deer and cares for many Rimbey and area patients, has offered to provide medical support for a dialysis unit. A number of the nursing staff currently working in the Red Deer dialysis unit have also offered to staff a unit in Rimbey. This option is currently being offered to other Alberta rural communities with similar challenges to accessing dialysis services.[33]

Mobile Dialysis Treatments (satellite)

Alberta has been innovative in utilizing mobile dialysis units to provide dialysis treatments to rural residents in northern and central Alberta. Recognizing that the health care system can't establish fixed dialysis units in every local centre, mobile units are seen as being a cost-effective way to bring renal dialysis to communities in need. Nurses and specially trained drivers staff the unit as it moves from community to community. Having a mobile unit can be cost effective as it is docking at a local centre, usually a hospital, to connect to water, sewage and electricity. Mobile units are capable of treating six patients on board, and connecting them with doctors in Edmonton via satellite. Such innovation enables patients to be treated locally, saving them considerable time, money, and the stresses of having to travel.

While several rural communities have been provided with a mobile dialysis unit that provides treatment to patients in their communities, Rimbey has not been offered this option.[34] Issues with staffing and equipment breakdown may not make this an optimal solution,[35] but it

[33] McKinley, R. "Cadzow to have full-time dialysis." Lac La Biche. Mar 27, 2012. http://www.laclabichepost.com/article/20120327/LLB0801/303279963/0/LLB.
[34] Ramsay, C. "Medical milestone marked at University of Alberta hospital". Wednesday, December 19, 2012.
http://www.globaltvedmonton.com/Pages/Story.aspx?id=6442775760.
[35] Dubois, S. "Dialysis bus stops working for over a week." Lac La Biche Post. Jan 11, 2011.
http://www.laclabichepost.com/article/20110111/LLB0801/301119964/-1/llb/dialysis-bus-stops-working-for-over-a-week.

may still be an option worth exploring to address the needs of rural communities in west central Alberta.

Store-Front Dialysis (satellite unit)

Two dialysis units have been established in shopping centres in Calgary that provide easier access for patients there, saving parking expenses and enabling anyone accompanying the patient to do their errands or shopping.[36] Rimbey could accommodate this in existing commercial or community space.

Home Dialysis

As previously discussed, home dialysis is another option available to individuals living with renal disease. This can include:

- Dialysis done 3 times a week similar to in-centre hemodialysis, but done at home.
- Short daily sessions.
- Nocturnal hemodialysis.

Each has its advantages and disadvantages. It may be less expensive overall for the health system, due to savings on staffing (e.g. nursing). While home dialysis allows for more control over schedules and greater life satisfaction for patients, there are costs associated with this option and:

- Home dialysis may not be suitable for all patients.
- Training is required over a period of weeks in order to properly operate equipment and dialyze successfully. Currently rural patients and an individual who will supervise the home dialysis must travel into urban centres for training. Training takes six weeks. The patient must pay for travel and accommodation expenses, which can be a significant cost.
- Introducing dialysis into the home will impact everyone in the home, for good and bad.

[36] Alberta Health Services (2013). Northland Village Mall: Programs and Services. http://www.albertahealthservices.ca/services.asp?pid=facility&rid=1009760.

- Space is needed for the dialysis machine and supplies, often requiring renovations to the home which can be costly and are not reimbursable.
- There may be increased utility costs. Supply management may require time during business hours e.g. to receive deliveries, to drop off blood draws.
- Technical support is at a distance, and in emergency situations, patients must call 911 and wait for a response. The response time in rural areas is also much greater than in urban centres.

One Rimbey patient who chose this option was left with $15,000 in renovation expenses that could not be claimed on income tax. The Northern Alberta Renal Dialysis Program only reimburses for $1,500 in one-time renovation expenses. The patient must then shoulder all further maintenance and renovation requirements. This constitutes cost shifting from the taxpayer to the individual, a form of privatization.

Telehealth

Telehealth refers to the use of information and communications technologies in health care and can have the potential to improve the health and health care of people living in rural areas. Teledialysis has been implemented in Saskatchewan, Newfoundland and Ontario to provide dialysis treatment to patients living in rural or remote communities. It saves patients the associated costs of traveling, and provides them with the care they need where they live. With an aging population, telemedicine is seen as a useful tool in helping to monitor and manage chronic diseases. In Newfoundland, local clinics around the province offer dialysis, and patients come in for treatment three times a week. The mobile Telehealth unit is moved from bed to bed while the patients are being treated and they meet with the doctors over the telephone while they are being treated. Saskatchewan has nine Telehealth sites that offer a variety of clinics including renal dialysis. In Ontario, connection has been established with the nephrology group at the London Health Sciences Centre using the Ontario Telemedicine Network (OTN) to utilize the concept of a virtual clinic.

Response to Rimbey Dialysis Challenges

The Rimbey and Area Renal Dialysis Support Group has attempted to work with the local MLAs and the Alberta Health Services, Northern Alberta Renal Program (N.A.R.P.) to get a unit established in the Rimbey Hospital and Care Centre. To date, these efforts have received the following responses:

- Can't have a dialysis unit in Rimbey because it is in the wrong postal code. Since at least six patients are required, there are not enough with the actual Rimbey postal code. Surrounding area postal codes were ignored.
- There was room in the new hospital; then there was no room in the hospital.
- When the minimum patient requirement was met, the Rimbey and Area Renal Dialysis Support Group was provided with a map with circles on it. At first they fell outside the circles so qualified, but at a later date were provided with a different map with larger circles and told that they were within a circle so didn't qualify for a unit.
- Since they were within a 100 km radius from the Red Deer dialysis unit, they were too close.
- Subsequently, Rimbey was told that it would never have a renal dialysis unit as long as Red Deer was not at capacity. Recent information suggests that the Red Deer dialysis unit has reached capacity and plans are in place to expand it.

Conclusions

The *Canada Health Act* is intended "to ensure that Canadians have universal and reasonable access on uniform terms and conditions to a comprehensive range of physician and hospital services on the basis of need and without regard to individual ability to pay."[37] Research over the past two decades has identified clearly a growing gap between rural and urban Canadians in access to healthcare services. The Rimbey and area dialysis case described in this document provides a good example of the growing inequality in reasonable access to healthcare services for rural residents in Canada.

[37] *Canada Health Act*, s12 (1) (a).

Diabetes and ESRD are significant and growing health issues in Alberta. Rural and elderly Albertans are disproportionately affected by these medical conditions. Alberta is a leader in the treatment of diabetes and ESRD. Ongoing research for the Alberta Diabetes Surveillance System has recommended that government "enhance access to allied health professional primary care providers, particularly in rural and non-metro health zones"[38] and "ensure an adequate supply of primary care providers and access to all diabetes services in all areas of Alberta."[39]

Currently, there are options available through Alberta Health Services for the treatment of ESRD outside of urban hospital settings and in rural communities. Satellite renal dialysis occurs in mobile buses, in-home self-care, and through store-front facilities in shopping malls. A number of rural communities currently access renal dialysis through a fully equipped mobile bus that travels to their community and connects to water and power infrastructure through local hospital facilities. However, Rimbey is not one of these communities. Residents in one Calgary neighbourhood access dialysis services conveniently through a store-front facility in a shopping mall.[40] [41]

Currently, Rimbey and area dialysis patients travel over 1,000 hours/month; use their own vehicles for transportation; enlist a volunteer to drive them when possible; travel on statistically dangerous roads; and pay more than five times as much as urban residents to receive the same healthcare service. As already noted, Rimbey and area dialysis patients have been seriously injured, nearly killed or killed while travelling to and from dialysis appointments in Red Deer (see Attachment 1). Urban Alberta residents have access to door-to-door public transit if they choose.

Overall, rural residents receiving renal dialysis in Alberta are subject to cost shifting, a form of privatization. In addition, urban dialysis patients receive preferential access to dialysis services because rural dialysis

[38] ADSS (2011). "Key Findings and Policy Options" (chapter 13). Alberta Diabetes Atlas, 217. http://www.albertadiabetes.ca/documents/AtlasWeb.pdf.
[39] ADSS (2011). "Key Findings and Policy Options" (chapter 13). Alberta Diabetes Atlas, 218.
http://www.albertadiabetes.ca/documents/AtlasWeb.pdf.
[40] Alberta Health Services (2013). Northland Village Mall: Programs and Services.
http://www.albertahealthservices.ca/services.asp?pid=facility&rid=1009760.
[41] Alberta Health Services (2013). Northland Village Mall: Programs and Services.
http://www.albertahealthservices.ca/services.asp?pid=facility&rid=1009760.

patients pay significantly more than comparable urban patients to receive the same service and are sometimes diverted to other urban centres for treatment when they cannot be accommodated in the larger urban centre.

All of the above seems to be contrary to the *Canada Health Act,* the Alberta Health Services mission statement, current research on diabetes services in Alberta, and the Alberta Rural Development Strategy that has clearly indicated that rural hospitals should be used to ensure rural Albertans have access to quality health care. Rural hospitals are also seen as a source of economic development, offering employment to local residents and building community capacity and sustainability.

Although Rimbey has a relatively new hospital that could accommodate either an in-centre dialysis unit or a mobile facility, a storefront operation could be accommodated in the downtown and the existing Red Deer renal dialysis unit medical staff (nurses and nephrologist) is supportive of providing services in Rimbey, to date these options have been rejected by N.A.R.P. and Alberta Health Services.

Given the demonstrated safety concerns and financial barriers currently faced by Rimbey and area dialysis patients, is the access they receive to renal dialysis services *reasonable* relative to comparable patients within 70 kilometres of them receiving the same services, or do urban residents within the same geographic area, with the same medical conditions, seeking access to the same services, receive preferential access? How does this fit with the guiding principles of Alberta Health Services?

Recommendations

The following recommendations are based on the evidence presented in this document and are consistent with Alberta Health Services guiding principles:[42]

1. In partnership with the Rimbey and Area Renal Dialysis Support Group, Alberta Health Services and the Northern Alberta Renal Program develop a detailed case illustrating costs/benefits for all options available to Rimbey and area renal

[42] AHS (2012). "Fine Tuning Alberta's Health System." http://www.albertahealthservices.ca/7502.asp.

dialysis patients, consistent with the principles of the CHA, the Alberta Health Services mission "to provide a patient-focused, quality health system that is accessible and sustainable for all Albertans" and the goals and objectives of the Alberta rural development strategy.

2. In partnership with the Rimbey and Area Renal Dialysis Support Group, other rural communities, Alberta Health Services and the Northern Alberta Renal Program, establish strategies to address effectively and equitably the needs of rural dialysis patients in Rimbey and other rural communities in Alberta.

3. In partnership with the Rimbey Area Renal Dialysis Support Group, other rural communities, Alberta Health Services and the Northern Alberta Renal Program, ensure public availability of relevant information and transparency in decision making and resource allocation for dialysis services. Albertans want to know how decisions are being made, and that decisions are open and fair. Involving rural communities in a meaningful way and carefully considering their quality of life when making decisions about their health and the health care services they receive is a key part of a patient-focused approach to health care.

Attachment 1: Examples of the Barriers Faced by Rural Dialysis Patients

Some examples illustrating the nature of the challenges faced by some rural residents who must drive quite a distance into an urban centre to access medically necessary dialysis services are provided below. These examples are based on true stories provided by rural Albertans. There are many stories like this. Names have been changed to protect privacy.

Example 1: The Near Miss

The roads in the winter are unpredictable. One night after dialysis Jack and Mary had good roads to Sylvan Lake. Then all of a sudden we came over a hill and hit black ice. The traffic was slowed to 30 kph. Jack looked back and saw a tanker truck directly behind them starting to come alongside of them. At first they thought the truck was trying to pass which would have been very dangerous because there were five vehicles ahead of them. Then Mary realized the truck wasn't trying to

pass them, just trying to miss them and slow down. After the truck was able to slow down, it pulled over and stopped. Jack and Mary did not see the truck pull out again before they were out of sight. Jack and Mary consider themselves lucky that the trucker was such a good driver.

Example 2: The Accident and Lengthy Hospital Stay

In December 2010 one rural dialysis patient Gerry had an accident coming home from dialysis. It was storming, roads were ice and snow covered and it was still snowing and blowing. Gerry couldn't control the car and it hit the ditch. Luckily a truck came along and phoned the ambulance. This accident resulted in a broken hip and part of one arm and almost a four-month stay in hospital. Based on an average cost/day for a hospital stay in Alberta, the cost of the four month hospital stay cost the Alberta taxpayer (120 days X $1,611 per typical day) $193,320. It is almost 2 years later and Gerry cannot walk without a walker. In September of 2011, Gerry and his spouse Jean left their home in rural Alberta to move to Red Deer after driving the road between Rimbey and Red Deer for over 10 years. There is also an added cost to this. They now have double payments on all utilities, taxes and insurance.

Example 3: Travelling for Dialysis Can Kill

Heather who had been driving her son Jim from outside of Rimbey for dialysis into Red Deer four times a week for ten years, and had herself recently (one year ago) become a dialysis patient, was in a car accident on her way home from her own dialysis treatment. Due to complications from injuries that occurred during the accident, Heather died. Her husband Bill now drives Jim to Red Deer for dialysis. Because Bill owns and operates a business, he must shut down his business at least 16 hours per week. He drives his son into Red Deer, drops him off, drives back to his business outside of Rimbey and then returns to pick up his son from dialysis at the end of the day.

Example 4: Depression Caused by Leaving Home

Charlie, who was born and raised on his farm, married, raised his children and spent his entire life there, needed dialysis. For the first few years of seven years relatives drove him to and from Red Deer. Later he stayed with a friend in Red Deer during the “poor travel” winter months. Finally he felt he was infringing on family and friends too

much and moved into Red Deer, leaving behind his beloved farm and friends and community, trying to get a ride out to the countryside on the odd weekend. Even that came to an end. Charlie died away from the farm he built, and the community he loved and contributed to so much.

There are many other stories and testimonials including deciding to miss a dialysis treatment altogether because travelling is just too treacherous and stressful, but missing a treatment is also a gamble for many needing dialysis.